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Thukela District Child Survival Project (TDCSP)
THUKELA DISTRICT INTERSECTORAL HIV/AIDS/MED PROJECT
Okhahlamba, Thukela District, KwaZulu Natal Province, South Africa
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Thukela District Child Survival Project
HIV MED Grant Amendment

Third Annual Report
October 2002

Contents

List of Acronyms

BBAC	Bergville Business Advice Centre
CHC	Community Health Committee
CHW	Community Health Worker
CL	Christian Listeners
CRC	Children's' Rights Centre
DBSP	Dynamic Business Start up Program
DOH	Department of Health
DRA	Data Research Africa
HBC	Home Based Care
HEARD	Health Economics and Research Division (University of Natal)
HH/CC	Household and Community Component (of IMCI)
HIS	Health Information System
HIVAN	HIV/ AIDS Networking
HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome
IMCI	Integrated Management of Childhood Illness
KZN	KwaZulu Natal
LQAS	Lot Quality Assurance Sampling
MCO	Micro -Credit Organisation
MED	Micro-enterprise Development
MTE	Mid Term Evaluation
NGO	Non-governmental Organization
OADP	Okhahlamba Area Development Program
OVC	Orphans and Vulnerable Children
PLA	Participatory Learning and Action
PVO	Private Voluntary Organizations
SA	South Africa
TDCSP	Thukela District Child Survival Project
TL	Transformational Leadership
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WV	World Vision
WVSA	World Vision South Africa
WVUS	World Vision United States

1. Introduction

World Vision South Africa, in partnership with the Department of Health, was awarded a grant for the Thukela District Child Survival Project (TDCSP), a follow on grant that started in mid November 1999. The TDCSP is working to reduce the maternal, infant and child morbidity and mortality through a number of interventions, one of which is the HIV/AIDS/ Well-being intervention. An amendment to this grant was awarded starting in December 1999, called the Thukela District Intersectoral HIV/AIDS/ MED project. The amendment grant is for an intervention located in the Okhahlamba Municipality of the Thukela District.

The Okhahlamba Municipality has a population of 130 000 which includes 19 800 children under five, and 30 000 women 15-49 years of age. The population is mostly poor and rural. The majority of people live on tribal lands (80%), freehold land areas (10%) and on commercial farms (10%). Poverty is widespread- KwaZulu Natal Province (KZN) has at least 59.3% of children living in poor households. Statistics for the province of KwaZulu Natal, South Africa, where the project is situated, indicate that 33.5 % of women attending antenatal clinics are HIV positive (National statistics, 2001).

The HIV/MED grant amendment broadens the activities of the TDCSP (women and children under 5), to include other activities than those normally undertaken by Child Survival Projects. The project seeks to find creative new ways to impact vulnerable households[1] and individuals, and thus enable families to work towards children's' well-being in the context of HIV. The current context is one of hopelessness, despair and death, and the work of the project seeks to transform the context to one of legitimate hope, and planning for the future.

Previous research and evaluations in Okhahlamba Municipality, where Bergville is located, have indicated that socio-economic factors affect women's ability to engage in less risky sexual behaviour, and that giving knowledge, skills and motivation is not enough to promote safe sexual behaviour. Stigma is still prevalent, and affects households' and communities' capacity to respond to the effects of the HIV epidemic. A major factor contributing to the inability of households to cope with the 'shocks' (financial and other) is poverty.

This amendment project aims to increase the capacity of vulnerable households to respond to the social, health, and economic impact of HIV/AIDS on the households, by addressing some of the factors mentioned above. It is doing this by providing micro-enterprise training, facilitating a home based care network, raising community capacity to deal with orphans, and developing awareness messages and labour saving technologies. This is an integrated response, that involves many sectors, and community based organisations. A feature of the project is the linking of micro-enterprise activities with home-based care and orphan activities. This has generated the necessity of developing tools to measure whether micro-enterprise activity does indeed allow vulnerable individuals and households to respond positively to the impact of HIV and AIDS.

A mid term evaluation of the project was carried out in November 2001, which is available on request. Thereafter a No Cost Extension request for the project was submitted, in order to extend the duration of the project until July 2003 (see Annex 1).

[1] A vulnerable household is one that has someone seriously ill or that has or has taken in orphans.

Partners

Current key partners include:

Dynamic Business Start-up Program (DSBP)
Data Research Africa (DRA)
District Department of Health (DoH)
HIVAN (HIV/AIDS Networking)
Okhahlamba Area Development Project (OADP)
Christian Listeners (CL)
Bergville Business Advice Centre (BBAC)
University of Natal: Department of Community Health
Child Rights Centre (CRC)
Ncedisizwe Micro-Credit Outlet

2. Project Goal, Objectives and Progress towards them

Project Goal: To strengthen the capacity of vulnerable individuals, households and communities to respond to the economic, social and health impact of HIV/AIDS on their households.

In order to achieve this goal, the objectives given in the following table were formulated. The second column of the table gives an overall estimation as to whether or not progress towards achieving the objective is on target. This is a broad overview; details describing activities and measurements are given further in the report.

Objective	Progress on target?	Comments
1. Households with acutely /chronically ill family members OR households that have taken in orphans, will maintain or improve their incomes through MED activities	Yes	Identification of suitable trainees from vulnerable households has not been straightforward (see Annex 2 for list of trainees and vulnerability classification).
2. Increase in women and youth's ability to provide financially for their households and decrease their risk behaviour, through involvement in MED linked activities.	Yes	- Financial provision for some families has increased (see Annex 3 for analysis of business performance) - Possible changes in risk behaviour are still being measured
3. Increased awareness of and response to the HIV/AIDS pandemic among civil society, local institutions/ groups and intervention target groups through activities such as labour saving, collaboration and networking within the community.	Yes/ No	Awareness and response is on target, however activities such as labour saving are not on target and now appear be less appropriate than other activities. Good collaboration and networking is occurring.
4. Households with acutely or chronically ill family members will have improved knowledge, skills and support to care for the	Yes	Households sometimes leave the task of caring for the ill to the home based carers, rather than using their own

Objective	Progress on target?	Comments
chronically ill.		knowledge and skills
5. Households and communities with orphans will have appropriate awareness and knowledge to care for the orphans.	Yes	An (orphan) intervention is being piloted in six communities, however awareness raising is throughout the municipality
6. Project experiences / lessons for MED and care /support activities among vulnerable households and communities will be documented and shared with policy makers, practitioners and communities in KZN, SA and beyond.	Yes	There is continuous interaction with Government Departments, academic institutions, other NGOs etc. Intervention messages, baseline data, interesting findings, reports are circulated to interested stakeholders
7. Sustainability: Ensure that effective program components can continue after project completion and be taken to scale.	Yes/No	There are plans for the sustainability of the project in Okhahlamba, however, no plans as yet to go to scale throughout uThukela District

3. Major Activities and Achievements

The HIV/MED team works together with DoH and other partners for integrated implementation of interventions.

Micro-enterprise Development

- Training of people has continued, with 6 training courses having being offered since the Mid Term Evaluation (Nov 2001). These training courses have particularly targeted vulnerable households and individuals in a total of 10 communities. This has resulted in a total number of 200 people having been trained under the auspices of the amendment grant. The OADP, a major partner in the area, has also trained 196 people using the same training. Thus MED training for the project is complete, and the remainder of the project will be spent in follow up, disseminating messages and measuring impact.
- Follow up of trainees has continued, and the results are given in a Table in Annex 3 (Analysis of the DBSP training). The results show that a large percentage of trainees are keeping their businesses going for at least 6 to 10 months, and longer. (Statistics for these will become available gradually, as the time period from date of training increases- a staggered training program has been followed - see Survey Table in Appendix 4). The follow up results also indicate that for 47% of the businesses, monthly turnover is still below R500, (this approximately equals the monthly Old Age Pension from Government) although 18% have a monthly turnover above R1000.
- Two extra MED trainers and 2 additional follow up agents have been identified and are being trained, in partnership with DBSP, in order to address the training and follow up needs generated by the interest shown in the project by the OADP. The local Micro-Credit institution also prefers the people accessing micro-finance loans to have MED training.
- A graduation ceremony was held for 291 trainees who had been running businesses for 3 or more months. This was an occasion of great hope and rejoicing and gave the project local and provincial exposure.

- A database for trainees has been developed to collect data about which category of household and individual the trainees fall into (i.e. household with someone ill, or that have taken in orphans, or neither, and women and youth) (see Annex 2).
- DBSP held their national conference in Bergville in order to see the work that has been done in July 2002 and learn from the best practice here.
- The economic survey tool that is used to track changes in household economics, has been further developed to track changes due to economic activities around MED; and try and track how the income from the business is spent, e.g. whether directly or indirectly on the needs of children.
- Local government has been oriented to the project.
- Links have been made with Provincial Government, in order to explore possibilities with provincial Economic Development activities.

Home Based Care (HBC)

- Since the Mid Term Evaluation in November 2001, 76 of 90 Home Based Care (HBC) givers have been offered training in First Aid.
- These 76 have also had Christian Listeners (CL) training, which is Active Listening, a skill much needed for the HBC givers. Sixteen of them have received training in Listening in the context of HIV/AIDS. This training is a basic training that will aid in identifying HBC givers to go for more advanced counselling training.
- The referral system between the hospital, clinics and HBC givers has been strengthened to some extent, with the 'Evaluation of HBC' document produced by this project being especially useful in enrolling the hospital doctors about the work of HBC.
- A well-being card has been designed that each patient or client will have. This card will have a number of details about the client's well-being, including the referral form.
- The project HBC manager has worked closely with the DoH in facilitating the accessing of supplies for HBC, such as gloves. The DoH requested the project's help in spending the departmental HIV/AIDS budget e.g. ordering and delivering supplies for HBC.
- The project has worked closely with the DoH in regarding to supervision for the HBC givers. Currently the HBC givers meet at the clinics to report their activities and receive assistance where necessary.
- A major advance has been the development of support groups for the HBC givers. This is an initiative of the Christian Listeners organisation, working with the project. The HBC givers meet once a month in small groups in their areas with a facilitator. The support groups have greatly assisted the HBC givers, who have stressful contexts, in addressing their personal concerns, rather than sorting out concerns about patients, which is done in the meetings at the clinics.
- Some of the HBC givers have been elected to form part of the OADP HBC team. The project staff have helped the development teams to do their project planning
- The 'Evaluation of HBC' report was used to give input to the provincial KZN team setting up monitoring and evaluation of HBC for the province.
- 2 HBC conferences were held where the HBC givers were encouraged by motivational speakers and supplied with HBC kits, umbrellas and training certificates.

Orphans

- Training of the staff member responsible for orphans has been as follows (since the Mid Term Evaluation November 2001):

- Participatory Learning and Action (PLA) training from the Agromisa organisation, for community engagement and facilitating action
- Behaviour Change workshop, run by CORE Social and Behaviour Change working group and the CHANGE Project (Academy for Educational Development). World Vision Africa Technical Services hosted the workshop on behalf of World Vision US in order to learn current principles of behaviour change for application in work with communities
- Lot Quality Assurance Sampling (LQAS): A monitoring and evaluation tool/ technique to be used in the project

- The orphans' intervention has decided to intensively pilot some activities in six wards of Okhahlamba Municipality. These activities are as follows:

- Identify the orphans aged 15-25 in the community, through HBC givers and Community Health Workers.
- Meet with them and run focus groups around what is known about orphan issues and what their concerns are.
- Develop messages in order to address these concerns.
- Facilitate workshops around their vision for themselves and what has to be done to make the vision a reality.
- Facilitate projects that come out of this process, such as gardening for growing food and chicken projects.
- Engage the other stakeholders in the community and facilitate a relationship. These stakeholders include concerned church members, teachers, grandmothers looking after orphans and the Department of Social Development etc.

The orphan intervention approach uses the Transformational Leadership (TL) processes and principles, as well as some of the PLA tools for community engagement. This is an intensive approach, and cannot be carried out throughout the whole municipality within the time frame of this project.

- Out of the identified orphan groups, orphans with potential to be facilitators themselves have been identified.
- The person responsible for the orphan project has also worked closely with the TDCSP in the IMCI[2] household and community component and thus knows all the Child Survival activities for Child Health.
- A project staff member has helped facilitate meetings for the OADP orphan team and helped with planning, etc.
- The results of an Orphan Survey carried out by a Masters Student from Yale University during July 2001, are now available (see Annex 5). This survey shows that orphans in Okhahlamba are being looked after mostly by the extended family, and that they are managing to go to school. Their material needs are being catered for as far as the families are able, but families are living in poverty, and thus find it difficult to support extra members. Results from this study suggest a general lack of awareness of the existence of government sponsored welfare grants with only 3.8% of caregivers of orphan children receiving any kind of assistance. Only 50% of the children sampled could produce their birth certificate and immunization cards, documents that are crucial for applying for these

[2] IMCI stands for Integrated Management of Childhood Illness and includes the 16 key family practices for the Household and Community Component- HH/CC.

welfare grants. Caregivers in households also expressed a need for food, clothing and help with schoolwork (Kapoor, 2002). These findings have been used to inform the Orphan intervention activities.

Cross cutting activities

- A pre training program is being developed, with messages for workshops with the community being formulated. Topics that have been covered are: Entrepreneurship, Banking (You and your money), Safe use of Paraffin, Safe use of Electricity, Home Based Care, Orphans, Voluntary Counselling and Testing (VCT), Grants and Documents, Nutrition and HIV/AIDS. Some of these messages have been delivered in workshops to community members. (Modules and messages are available on request)
- Staff members from MED, HBC and orphan interventions have been trained in the modules of the Transformational Development Program. These include: Transformational Leadership, Facilitation, Coaching and Self Efficacy in order to use these skills in their work in the community.
- Intersectoral work: HBC and Orphans interventions have been working with other sectors such as the Departments of Health, Social Development (formerly Social Work), Home Affairs and Agriculture. Information and processes have been shared.
- Risk Behaviour and General MED surveys: The (sexual) Risk Behaviour questionnaire and the general questionnaire have been drafted. The Risk Behaviour questionnaire has been used with trainees. The General MED questionnaire has questions about HIV positive living, and HBC and orphans, in order to measure changes in community knowledge and context (see Annex 4).
- The project continuously shares its experiences and information with a very broad range of stakeholders and practitioners. Examples are Local Government, Provincial AIDS Action Unit, HIVAN (a NGO attached to the University of Natal, that is networking throughout KwaZulu-Natal, South Africa and globally) etc. HIVAN has recently asked that the health messages compiled be put on the Web for wider access. WVSA has agreed to this, once the correct references and acknowledgements are in place.

4. Problems/Constraints and how they have been addressed

1. The interventions to achieve Objectives 1 and 2 are focussed on training members of vulnerable households and individuals in Micro-enterprise activities. The course is intensive, and there is a follow up program to ensure that the businesses successfully get over their most vulnerable time, the first 18 months of operation. In order to train and follow up people all over the Municipality, there was a need for more trainers and follow up agents. In partnership with DBSP, the process of recruiting and training more trainers and follow up agents has started.
2. In a study/ project of this nature, households may shift categories during the course of the project. For example, a household may have no ill person when the micro-enterprise training takes place, but may shift when someone becomes ill. Similarly, a household that starts as a household with someone ill may experience the death of that person, children may go and live elsewhere with other family members and the household may thus become one without an ill person or orphans. A database is being complied to try and track these changes (see Annex 2)
3. The micro-enterprise training is aimed at entrepreneurs, as these are the people best able to start and sustain businesses. The project aims to target vulnerable households, and there may in fact be no person that displays entrepreneurial flair in many of these

households. In order to also offer these people some training the pre-training modules were developed.

4. The nature of the project area (rural and covering a wide geographical area, sometimes fairly inaccessible), coupled with the nature of the training (intensive, lasting 4 weeks, with alternate days spent in the classroom and in the field doing practical work) has meant that training of participants has been in selected geographical areas, with 20 participants per course. At the mid term, only 78 participants had been trained under the auspices of the project, whereas the numbers have risen to 220 by September 2002.
5. In order to measure whether the micro-enterprise activities are having a positive economic impact on households and individuals, an economic survey tool was required, which track where funds generated in the micro-enterprise activities go. This has been developed in partnership with DRA, and is being piloted. Likewise, a tool for measuring sexual risk behaviour had to be developed (although there are a number of tools available, none of them was completely aligned with what the project wants to measure). A third tool, which can measure knowledge of messages around positive living, home based care, and orphans has been drafted. A tool for measuring what is delivered to clients in the Home Based Care Program was adapted and used as well. These address Objectives 1 to 5 (see Section 2, above).
6. Although the tools described above may be able to measure changes at household and individual level, the project is committed to shifting the context around HIV and AIDS, and bringing legitimate hope. This requires qualitative measures, such as the development of indicators for well-being. A partnership with HIVAN and the Department of Ethnography/Anthropology at the University of Natal has been initiated, in order to develop this facet of the project. The management will also assess whether the definitions and indicators of risk and well-being developed through the Monitoring and Evaluation framework of the IMCI HH/CC of TDCSP, can be applied here.
7. Attempts to provide knowledge, skills and motivation have been shown to be ineffective in shifting the context around HIV. A series of training workshops in Transformational Leadership and Self Efficacy has the potential to shift the context. This training of facilitators and coaches was offered from July to November 2002.
8. Although there is much information available about home based care, positive living, orphans etc, the project needed a series of messages capturing this information that could be used for workshops with community members. These have been formulated and are available on request
9. The nature of the microenterprise activities in a poverty stricken area generates the possibility of needing access to microfinance, not as an absolute necessity, but as an enhancer of business activity. With this in mind, links have been made with the local Micro- credit institution, Ncedisizwe, to allow trainees to access loans if they desire.
10. The orphan intervention has been piloting an approach with older orphans (15-25 years). Activities to address the needs of young orphans need to be developed, although they are addressed in the general messages. A constraint in working with older orphans is that they are attending school during working hours. This has been addressed by meeting with them during weekends and school holidays.

5. Technical Assistance required

- As can be seen from the section above, technical assistance has been sought from local and other partners and consultants.

- HIVAN has been approached to assist with finding measures of legitimate hope and to see if the program interventions are contributing towards this outcome.
- DRA is assisting with design of appropriate tools, and data entry and analysis for the household economic survey, the risk behaviour survey, and the change in knowledge and practice of health messages.
- An outside consultant will be required to do the End of Project Evaluation in July 2003.

6. Changes from the initial description of the project and DIP

A major change has been the request for a No Cost Extension of the project. This was requested due to the nature of micro-enterprise business in a survivalist context. In order to see whether micro-enterprise activity does indeed make households and individuals more resilient to shocks, the businesses need to run for longer than 18 months

7. Recommendations from MTE

Overall recommendations

- **Build stronger links between project components or interventions:** These linkages are much stronger since the MTE. HBC givers assist in identifying vulnerable households and individuals. Some HBC givers have also participated in the MED course. The links with the Orphan intervention are less strong. Messages will be delivered to roleplayers in all three groups, which will also help in promoting sharing and linking.
- **Develop strategies for Objectives 3, 6 and 7:** There is a strategy around Objective 3 (increased awareness and response to epidemic among civil society etc). This involves message development, dissemination and measuring changes in awareness and response. Objective 6 (Project experiences documented and shared) has started being addressed in partnership with HIVAN, a networking organisation with links within South Africa and internationally. Objective 7 is a sustainability objective. The strategy for this is described in Section 9, below.
- **Message development:** This has been addressed, and will form a large part of the activities of the project in the next few months.
- **Redefine indicators so they are stated in neutral terms:** This has not been done but will be addressed before the end of project evaluation
- **Develop a systematic monitoring and evaluating plan:** Monitoring for the MED and HBC intervention has been strengthened. Community monitoring of orphans in the 6 pilot sites has been started. However, an integrated plan has not been developed.
- **Work more closely with Government sectors:** This has been addressed particularly by the HBC and Orphans interventions.

Intervention recommendations

MTE recommendations have been addressed within each planned intervention, in accordance with the Work Plan drawn up in January 2002. However, the time frame for activities has been changed. (See Annex 6).

MICROENTERPRISE DEVELOPMENT

Evaluation Recommendation:	Response
Target vulnerable households for MED trainings.	• Vulnerable households are identified by organization and structure i.e. HBC givers, CHCs and CHWs. (Some of HBC givers have been trained.) • Trainees include people from vulnerable households with ill family members and orphans, identified by HBC. Most individuals being trained in MED are women and youth
Link those not accepted for MED with skills trainings.	To be addressed in 2003
Linkages with outside markets and Local Government.	Each group of trainees is introduced to other economic development initiatives in the municipality and in the district that they could link with, as part of their training program. This also included the OADP programs.
Community mobilization for MED, HBC, orphans.	Awareness of the project and involvement in the interventions is widespread in Okhahlamba, both among the community and Local Government. Message dissemination to begin last quarter of 2002.
Orientation course for MED activities.	Orientation course for MED have started: Modules on Banking, Entrepreneurship and the Use of Paraffin. However, it was felt that numeracy and literacy training as advocated in the MTE recommendations is beyond the scope of the project. During the month of MED training, these are addressed as far as possible.
Transformational Leadership training for MED trainees (Visioning)	Trainers and Follow-up agents have been trained as facilitators and coaches to offer Transformational Leadership to MED trainees. This will begin in Jan 2003 after the Christmas break.
Design a section about Micro-Credit as part of MED training package.	The MED project is in partnership with Ncedisizwe MCO where Micro-Credit information is formally disseminated to the people There is also a section on Micro-Credit in the DBSP training program.
Strengthening coaching and monitoring for trainees.	With DBSP, follow up has been strengthened by training extra follow up agents, and by giving extra training in coaching. The follow-up of trainees fell behind and is now catching up as there are more competent follow-up agents trained and working
Link more strongly with other institutions -BBAC -OADP -Ncedisizwe Micro-Credit	Networking between MED, BBAC, OADP and Ncedisizwe has been strengthened and there is significant interaction among these local institutions
Finalize suitable tools for measuring baseline data for households participating in MED intervention.	• The Household Economic Expenditure questionnaire has been expanded to track movement of money generated during MED

Evaluation Recommendation:	Response
	movement of money generated during MED activities. • The expanded questionnaire has been used with new trainees.

ORPHANS INTERVENTION

Evaluation recommendation	Responses
Co -design targets for holistic community care for orphans with orphans and community members	Holistic community care is a focus of the vision for the orphans pilot projects, as formulated by orphans themselves. Some targets/ milestones have been set in the pilot projects, but the process is ongoing.
Listening and counselling skills for HBC, CHW and other community members	76 of 90 HBC givers have been trained in Christian Listeners, and 16 of 90 in Listening in the context of HIV and AIDS. Further training is still to be held
Research and advocate school feeding schemes.	• There will be a meeting with the Nutritionists of the Dept of Health, who are responsible for the school feeding scheme. However, food security is addressed as below: • Food Security through gardening and chicken projects - Orphan managed food security garden and chicken projects with OADP - 3 orphan groups have well fenced, planted gardens, which generate food and income. - 5 orphan groups have started chicken projects for economic development
Encourage church involvement. Engage school teachers and principals in the project	• 3 orphan groups have Orphan Ward Committees, which involve teachers and churches. • In two communities church leaders will be addressed about OVC.
Facilitate orphan participation in the project as decision makers (ages 15-25)	• Orphans design and carry out their projects • Transformational Leadership offered to help orphans design their projects.
Focus on children's rights	• Messages about children's rights have been formulated as part of the orphan messages. • Disseminated in workshops done in two communities. • Children's rights have been included in the Family Booklet for Child Health, disseminated by the IMCI project.
Compensate expectations raised by the orphan	• There is a growing understanding of a

Evaluation recommendation	Responses
register.	community based response to orphan issues in the pilot sites. • Communities are starting to take responsibility for the orphans in their wards, and keeping the information about the OVC in their own communities. • Local commercial farmers have donated 38 tonnes of maize to a Food Bank that the most vulnerable households can draw from through the Well-being Centres at ward level. The HIV/MED staff network with this infrastructure
Orphans experiences and lessons shared broadly among stakeholders.	Shared with HIVAN, Local Government and other orphan projects.
Sustainability plan for orphan intervention.	Developing future plans linked with OADP orphan project.

HOME BASED CARE

Evaluation Recommendation	Response
Training: Provide training in counselling and First Aid for HBC volunteers	• 76 of 90 HBC givers trained in CL, and 16 in Listening in the context of HIV/AIDS. Listening is a basic skill for counselling, and the courses will help identify those HBC givers who would be effective counsellors/coaches • First Aid training to 76 HBC givers. • The staff, DBSP Trainers and follow-up agents all attended Transformational Leadership training, Facilitation, Coaching, Self Efficacy, in order to offer TL to community members + HBC givers in 2003
Recruit and train more volunteers	Communities have identified people to be trained as volunteers. However, training has not gone ahead as the issue of incentives for HBC givers has not been resolved, and the DoH is training CHWs in HBC skills
Strengthen and consolidate referral system between HBC givers, clinics and hospital. Workshops with HBC givers, clinic and hospital staff to improve trust Encourage holism in the care approach	• The system has been strengthened. Ongoing regular meetings with DoH will consolidate this. • These activities also engender knowledge and trust between roleplayers • A well-being card has been designed, but not yet piloted, to allow referrals between roleplayers. The card looks at holistic well-

Evaluation Recommendation	Response
	being for the client/ patient
Seek sustainable ways to supply families with needed medical supplies and medicine	• This has been addressed for Okhahlamba, with systems and processes being set up to facilitate families getting what they need • The project is still awaiting supplies to be sent as Gift In Kind for distribution to the HBCs
Investigate some form of compensation for the volunteers	HBC givers have received incentives such as umbrellas, HBC kits and other goods, in partnership with Dept of Health. No financial incentives are being given
Exit plan for HBC givers (i.e. HBC givers to train families, and not do the day to day care for each family)	Messages developed (see below) do describe the role of the HBC giver as that of trainer for the family
Refine and package HBC messages Message campaign against stigma	• HBC messages have been formulated • A message campaign against stigma is not planned. Rather, all the messages developed in the course of the project promote hope and caring in the context of HIV and AIDS, which does indirectly address stigma.
Develop formal monitoring and evaluation system for HBC: Plan regular monitoring and evaluation of the work of HBC givers.	HBC givers meet once every month at the nearest clinics and discuss and resolve their concerns about their client. HBC Support Groups also meet (through Christian Listeners)
Link HBC with orphans and MED activities. - Share HBC project information and messages with all MED course participants. - Share orphan project information and messages with all MED course participants. - Recruit MED course participants from households with ill family members and orphans.	• In process, to be completed in 2002 • In process, to be completed in 2002 • This has been done for all the trainings funded through this grant
Develop well-being indicators	This is in the early stages (the Well-being Referral card is a start in the process)
HBC experiences and lessons shared broadly among stakeholders.	• Sharing with HIVAN; Departments of Home Affairs, Welfare and Health; OADP and Local Government. • HBC conference for awareness raising and advocacy about the HBC program held in January 2002.

8. Activities targeted in the request for No Cost Extension and progress towards them

The following is a summary of the activities that were targeted for attention during the no cost extension request, which permits the work of the project to continue until July 2003.

Activity	Progress
Tracking the outcome of the MED, HBC and Orphan support activities on reduction of high risk behaviours and increase in hope	A (sexual) Risk Behaviour questionnaire has been developed and a baseline done. Measuring an increase in hope will be done through qualitative research, in partnership with HIVAN and the University of Natal.
Transformational Leadership training for MED participants	Trainers have been trained, roll out in 2003
Further development and dissemination of core messages for HBC and Orphan care. LQAS will be used to measure changes in knowledge and practice	The messages have been formulated, dissemination in 2003. A questionnaire is in rough draft, will be used for a baseline in 2002. LQAS methodology to be used for sampling. One staff member has been trained in LQAS.
Strengthen the MED component through creating linkages	A module on how to access micro-finance has been incorporated into the MED training. A session on local market opportunities is also given in each training session.
HBC intervention strengthened	Activities already undertaken described in the section above

9. DIP phase out plan

Objective 7 of the project addresses this: *Sustainability: To ensure that effective program components can continue after project completion and be taken to scale.* In order to address this, the following has been done:

- **Keeping the community central in designing, planning, and implementing the project**. Community workers and leaders were involved in selecting the participants for the MED programs. HBC givers are chosen by community structures, and supported through the formation of support groups (caring for the care givers). Orphan households are also identified and supported through community structures and community based workers. Once the messages have been disseminated community members will be better able to access government support intended for the vulnerable.
- **Continually building the capacity of the community and its individual members.** HBCs are now skilled in offering care and listening. Orphans are being trained to know their rights, how to access grants and are being engaged in projects through which they can provide basic needs for themselves and their siblings. People from more than 200 vulnerable households have been able to initiate and sustain a small business that is bringing needed income into the home. All training is followed up with monitoring and supervision support. To strengthen the sustainability of the MED

component, 3 local people are being trained as trainers, and 3 as follow-up agents of the Dynamic Business Start-Up Program. They are involved in this work as business people in their own right, and not as project staff members. There is a continuing demand for more training programs. In September 488 community people submitted their names to be trained in starting their own businesses. Businesses that form solidarity groups can also access micro-finance loans from the local MCO, to grow their businesses.

- **The project is continually encouraging mutual learning and sharing of information with the community, DoH, project staff, and other partners.** DoH officials addressing HIV/AIDS, as well as other local HIV/AIDS and MED organizations, have been invited to participate in training and evaluation exercises. Lessons learned are being documented and shared with stakeholders and through out the WV partnership and beyond.
- **Plans for staff:** These will either continue the work they are doing through OADP, or through projects that develop out of the findings of this operations research project.

10. Factors that have impacted positively/ negatively

Financial management
See this section under the main TDCSP grant

Human resources

- Formal staff development plans are now in place for all staff, and a formal performance appraisal is held with each staff member every six months. In this process plans are made for training in areas where staff competency needs improvement as well as steps each staff member wants to take to develop their career path. This process has helped the staff develop clarity in terms of what they are being held accountable to deliver and gives opportunity for formal feedback.
- The morale continues to be high and they have all developed beyond expectation in their competencies over the past year. The morning prayer/meeting times build team spirit and are used for weekly and daily planning.
- Each of the staff members has developed a personal vision for themselves and has started thinking about what they would like to do once the project finishes. No clear plans are as yet in place. If there were follow-on to this project it would be optimal that they transition into the next phase of this work and are not lost to the organization.

Logistics
The project is adequately resourced. The fieldworkers have an office with filing cabinet and access to computers. Transport for field work is also available when coordinated through the transport officer.

Communication

- The TDCSP and the HIV/MED grant amendment is integrally linked with the OADP. A communication network exists and communication with other community organisations and structures is easily facilitated through teamwork and through membership on the Okhahlamba Municipal Development Forum.

- Communication for the HBC and orphan projects is facilitated via the existence of the Core Teams of the OADP.
- Meetings to address issues of common concern with staff are held after morning devotions.
- More effort needs to be made to include key stakeholders in the developments within the project. However key documents are circulated to interested parties.
- Local councillors are kept informed of events happening within their wards.

Information management

- The economic Household survey has been and will be repeated at annual intervals with MED trainees in order to try and track what happens to the income earned through the businesses initiated.
- The data from the various research initiatives should give measures of program outcome by the end of the extension period in July 2003
- Both TDCSP and DBSP have a monitoring database for the DBSP trainees. This is a new development since the MTE (see Annex).
- Staff members submit monthly reports in which they track progress against their work plan and objectives. The Project Manager combines these reports in her report to WVSA Operations.

Local Partner relationships

This project would not be effective without the strong partnerships that have been developed since the initiation of this project. DBSP, HIVAN, DRA, BBAC and NMCO in particular add real value to the program

Effort has been made to define the roles, responsibilities and expectations of the various partners, through contracts and terms of reference where necessary.

PVO coordination/collaboration

See TDCSP report

11. Analysis of important issue/success/new methodology/new process: potential for scale up

- **MED training:** The MED training program offered by DSBP has been excellent, very suitable for trainees in the rural context of Okhahlamba, especially with the recent development of Zulu training material. The emphasis on a long period of follow up is one of the key factors contributing to the success of the trainees in maintaining their businesses for over a year, and longer. The project has already been scaled up in Okhahlamba, as the development project OADP has requested training of their people, as has the local Micro-finance institute. A further development that has been very positively received by community members is the 'Pre training workshops', around topics such as 'You and your money'. This pre training material has been developed in partnership with the DBSP, and they plan to use this training material in their other projects throughout South Africa.

- **New /further developed sampling tools:** Work has been done on 3 sampling tools. The Household Economic survey tool has been expanded to track movement of money generated in the business run by the MED trainee, and the Risk Behaviour and General questionnaire to measure communities responses to some of the effects of the AIDS epidemic have been developed. These tools will prove useful as a starting point for people wishing to measure these aspects. Further tools that have been used in the project are the HBC questionnaire that assesses what is being delivered in terms of information, skills and care to patients/ clients, and the orphan questionnaire to assess the household situation of orphans.
- **Orphan intervention: Linking TL with orphan activities:** The approach taken in the Orphan intervention is new, where a facilitator uses Transformational Leadership tools in facilitating a process with the older orphans. These tools include visioning, the Past/ Present / Future tool, Holistic Well-being, Clearing of Concerns and Dealing with Breakdowns. There has also been the use of Focus Groups, in order to gather information to use for message development. The intervention has been making great progress using these processes, and groups are looking to the future with hope, owning their projects, and working with their communities. This way of working shows great promise for roll out throughout Okhahlamba.
- **HBC Well-being Card:** In order to move away form the biomedical approach to addressing the effects of HIV and AIDS, a more holistic model is needed that takes care of physical but also psychological, social, spiritual and also developmental issues. The Well-being Card that will be piloted addresses these other aspects of well-being, and can be used to refer clients to many service providers outside of the Health services.
- **LQAS for sampling:** The Lot Quality Assurance Sampling methodology has great promise for use as both a monitoring and an evaluation tool. This well-known methodology has not been used to monitor for example HBC givers' quality of care. There is also great potential for using the methodology to track changes in perceptions, knowledge and behaviours in an HIV/ AIDS / Well-being intervention such as this.
- **Christian Listeners training And Listening to AIDS:** Develops the reflective listening skills of the HBC givers and gives them information and tools useful for their interactions with clients, in addressing concerns raised and moving clients to action to address concerns and become more positive (hopeful) for their future. This training has been reported to be extremely helpful in the work of the HBC givers. Roll out has started, as HBC givers throughout the uThukela District are currently being trained through a partnership between DoH, Christian Listeners and TDCSP.

12. List of Annexes

1. No cost extension request
2. Database of vulnerable households who have been trained in business.
3. Analysis of DBSP training/ Business Performance
4. TDCSP MED Surveys: a summary
5. Kapoor, S, 2002: A Needs Assessment of Orphan Children and their Caregivers in the KwaZulu-Natal Province of South Africa, a Thesis presented to The Faculty of the Department of Epidemiology and Public Health, Yale University, in Candidacy for the Degree of Master of Public Health**.**
6. HIV MED Work Plan.

Annex 1

Request for 12-Month No Cost Extension
World Vision, Inc
Thukela District
Intersectoral HIV/AIDS MED Response
USAID CSP Grant #FAO-A-00-99-00043-00

Project Background

The World Vision Thukela District Intersectoral HIV/MED Response Project is an amendment to the ongoing USAID Thukela District CSP, Grant #FAO-A-00-99-00043-00. The Intersectoral HIV/MED Response Project implementation period is from January 24, 2000 to July 24, 2002, while the Thukela CSP implementation began October 1999 and will continue through September, 2003.

The Intersectoral HIV/MED Response Project aims to increase the capacity of vulnerable households to respond to the social, health and economic impact of HIV / AIDS on their households. Through its interventions, the project seeks to bring hope and opportunities to individuals, providing motivation to reduce risky health behaviours. Program approaches include:

a) Micro-enterprise training for community members, targeting specifically vulnerable households, women and youth;
b) Establishment and support for a home based care network;
c) Strengthen the capacity of community networks to care for orphans;
d) Develop and disseminate HIV awareness messages and labour saving technologies. The project aims to bring hope to people, which it assumes will influence people to reduce risky health behaviour (particularly related to HIV).

Progress to Date

Project progress to date includes:

- 140 clients (out of a targeted 160) from vulnerable households have received Dynamic Business Start Up training. Ninety-one percent of these training participants are operating successful businesses (average $50 per month) with 56% of these individuals being youth and 85% women. Participants report an increase in confidence and optimism for the future.
- In partnership with Doctors for Life and the Department of Health, 100 community volunteers have been trained and have been well received within the community to providing training and support to families caring for ill members. This has been an important intervention to reduce hospital overcrowding as well as household expenditures for care.
- An orphan community register has been created and an Orphan Conference was held to build networks, increase awareness on child's rights and protection and mobilize community and other resources to support orphans.

Request for 12 month No Cost Extension

While community participation and ownership for the program interventions has been strong during the 30 months of implementation, further development of integrated messages across the program components needs to occur as well as evaluation of the impact of interventions on high risk behaviours. The project evaluation conducted in November 2001 has provided useful strategic directions and recommendations that are still in the process of being implemented. The project has been delayed it its spending and has an estimated $113,444 remaining (out of the total project $344,617), an amount sufficient to support an additional 12 months of implementation extending the project period to July, 2003.

The 12-month no cost extension period will target the following:

1. Tracking the outcome of MED, Home-based Care and Orphan support activities on reduction of high-risk behaviours and increasing hope. The monitoring and evaluation tool created to track outcome on participants' behaviour and levels of hope has just now been completed. Collaborating partners have included Data Research Africa, University of Natal, and the Human Sciences Research Council. The additional 12 months of implementation would allow for the tool to be utilized and program components to be further evaluated leading to recommendations for MED, HBC and orphan related HIV/AIDS interventions.

2. Transformational Leadership training for MED participants. Skills transferred utilizing transformational leadership principles have shown promise for motivating individuals to change their high-risk behaviour. Participants are supported to design/ envision their future and steps needed to reach their preferred future shifting the HIV context away from one of death, despair and isolation. Training is targeted for July 2002, with an expert trainer identified. A total of 200 clients will be trained and followed up with support activities. Two coaches from among the MED participants will be identified to support the followup among their peers.

3. Further development and dissemination of core messages for home based care and orphan care. LQAS will be utilized to measure changes among individual's knowledge and practice.

4. Strengthen MED component through creating linkages with outside markets, and training and support for Bergville Business Advice Center to followup MED clients. See attached workplan.

5. Home based care strengthened through: Consolidate referral system between clinics and hospitals and home based care activities; Implement client carrier cards for discharged patients; Provide first aid training and counselling skills to community volunteers; Transfer HBC activities to the WV Okhahlamba Area Devlopment Program; Conduct HBC conference for sharing promising practices. See attached workplan

Annex 2

MED TRAINING STATISTICS
FOR VULNERABLE HOUSEHOLDS FROM 10 PROGRAMS

Area	**No. of trainees**	**# Vulnerable**	**Children whose mother has died**	**Children whose father has died**	**Children with no parents**	**HH with ill people**	**Funerals occurred**	**Loan**
1. Bergville one	19	13	4	5	1	6	7	6
2. Bergville two	18	11	5	7	2	7	4	3
3. Rookdale one	20	17	6	9	3	12	2	2
4. Bethany one	20	20	7	10	4	12	4	9
5. Zwelisha two	20	19	6	11	4	15	4	12
6. Magangozi	20	20	7	10	8	9	11	12
7. Obonjaneni	18	13	5	11	2	5	5	10
8. Bhalekisi	16	15	5	8	5	11	10	14
9. Mhlwazini	21	13	3	8	1	8	0	0
10. Ngoba	14	13	5	12	2	11	12	0
OVERALL TOTAL	186	155	53	91	32	96	53	68

Annex 3

AN ANALYSIS OF THE DBSP TRAINING HELD IN BERGVILLE DURING 2001

September 2002

Outcomes Of The Intervention done in Bergville during 2001 (HIV/MED + OADP funded programs)

- Trained 296 people to start-up a business of their own via the Dynamic Business Start-Up Programme (DBS Programme).
- 291 of these people actually started up a business.
- Identified 2 people from Bergville who could be trained to run further DBS Programmes and to follow up programme 'graduates', thereby providing capacity to TDCSP.
- Commenced with the training of these 2 people.
- Translated the training materials into Zulu, so that it would be easier for the local people we are training to understand the materials and to achieve the outcomes of the DBS Programme.
- Built a strong interdependent relationship with the staff at TDCSP.

Outcomes Of The Training Process Itself

Number And Percentage Of Learners Followed Up And Whom Are Still In Business

Number Trained	Number that started up a business	Number followed up after 3 months	Number still in business 3 months after the course	Number followed up after 6 - 8 months	Number still in business 6 - 8 months after the course	Number followed up after 9 - 10 months	Number still in business 9 - 10 months after the course	Number followed up after 12 - 14 months	Number still in business 12 – 14 months after the course	Number followed up after 15 – 17 months	Number still in business 15 – 17 months after the course
296	291	282	270	292	280	180	160	65	50	37	30
	98.3%	95.3%	95.7%	98.6%	95.9%	60.8%	88.9%	21.9%	76.9%	12.5%	81.1%

Breakdown Of The Types Of Businesses Started And Their Percentages.

Trading	Service	Manufacturing	Trading & Manufacturing	Farming, with or without any other business type	Service & Manufacturing	Service & Trading
175	6	38	30	8	3	5
65%	2%	14%	11%	3%	1%	2%

Number Of Learners That Have Obtained Some Form Of Employment Since Completing The Training: 12

Number Of Learners That Have Passed Away Since Completing The Training: 2

Number Of Jobs Created (This Includes The Person Running The Business: 83

Breakdown Of The Monthly Turnover Of The Businesses

0 – R250	R251 – R500	R501-R750	R751 – R1000	R1001 – R1500	R1501 – R5000	Over R5001
35	93	40	53	30	18	2
13%	34%	15%	20%	11%	6.5%	0.5%

Number Of Businesses That Have Closed Down

Number of businesses that have closed down, where the person is now doing nothing	13	59%
Number of businesses that have closed down where the person has found employment	9	41%
Total number of businesses that have closed down	22	

Number Of Businesses That Are Busy Growing or Declining, or Have Changed

Number of businesses whose turnover we can say has improved or declined due to us having comparable statistics	114	
Number of businesses whose monthly turnover has improved	59	52%
Number of businesses whose monthly turnover has declined	52	46%
Number of businesses whose turnover has remained constant	3	2%
Number of businesses who have either changed their product, or have added an additional product	95	

Some Pertinent Notes On The Sets Of Statistics Above

- The Dynamic Business Start-Up Project (DBSP) is an education, training & development organisation, focusing on imparting skills. It is not a micro finance operation. Hence, it does not make funds available for business start-ups. However in the methodology of the DBS Programme learners are taught to start off with what little money they have. Hence, over 50% of the businesses started, did so without any financial assistance.
- It is our experience that most people from a previously marginalized, disadvantaged background start up businesses by looking over the fence, as it were, to see what others are doing. Then they copy – almost exactly – what they see someone else is doing. During our follow up process, we have noted that many people in the community are copying what our programme 'graduates' have started. Hence our 'graduates' have got to cope with ever increasing amounts of competition. We are amazed at how well most 'graduates' are coping with this pressure.
- Linked to the point above. It is very encouraging to see the number of 'graduates' who have either added a product, or have changed either their product, or their business. This is right in line with what they have been taught. In other words, they are taking the theory they learnt on the DBS Programme and are utilising it to beat their competition.
- It is very encouraging to see that even with the odds stacked against them, most of the 'graduates' are coping well, and that such a high percentage remains committed to their businesses.

Way Forward

The DBSP is busy putting the following into operation in Bergville to further sustain the work already started there:

1. We have identified another 2 people from the communities around Bergville and are busy training them to be DBS Programme Trainer/Facilitators.
2. In order to provide an even better service to the programme ‘graduates’ we have also selected a further 3 people whom we have trained to provide counselling and aftercare, follow-up services to the programme ‘graduates’.
3. This means that we have developed a team of 7 people who work on DBSP related matters in Bergville. Hence we are busy, and have made plans to further capacitate the area and the TDCSP Project.
4. We are also busy developing other complementary training interventions to further add value to the previously marginalized, disadvantaged people in the greater Bergville area, thereby also adding more value to both the OADP, as well as the HIV/MED sides of the project in Bergville.

Annex 4

TDCSP MED surveys: A summary

(Status in September 2002)

Project Goal: To strengthen the capacity of vulnerable individuals, households & communities to respond to the economic, social and health impact of HIV/AIDS on their households.

Project Objectives:

1. Households with acutely/chronically ill family members OR households that have taken in orphans, will maintain or improve their incomes through MED activities.
2. Increase in women and youth's ability to provide financially for their households, and decrease their risk behaviour, through involvement in MED linked activities.
3. Increased awareness of and response to the HIV/AIDS pandemic among civil society, local institutions/ groups and intervention target groups through activities such as labour saving, collaboration & networking within the community.
4. Households with acutely/ Chronically ill family members will have improved knowledge, skills & support to care for the chronically ill.
5. Households & communities with orphans will have appropriate awareness and knowledge to care for the orphans.
6. Project experiences / lessons for MED and care/ support activities among vulnerable households & communities will be documented & shared with policy makers, practitioners & communities in KZN, SA and beyond.
7. Sustainability: Ensure that effective program components can continue after project completion & be taken to scale.

This is an operations research project. The project has to measure whether MED training and subsequent small business activity allows households and individuals to counter some of the 'shocks' that HIV & AIDS generates. Another series of measures is around knowledge and practice with regard to sexual risk behaviour, and knowledge and perceptions about home based care, orphans and vulnerable children and healthy living for HIV positive people. Target groups are **households** with ill family members or that have taken in orphans, and **individuals**: women and youth.

1. **Rapid Household Scan:**

Purpose: A short 5-minute questionnaire to identify households with ill members or orphans, as well as sources of income etc., used to inform project design for which areas to target for project intervention.
Sample: Every third household in Okhahlamba (4159 households surveyed)
Status: Completed Oct 2000, report available

2. **Household Economic Survey**

Purpose: An in depth economic survey, gathering information about demographics, migrancy, services and facilities available to the households, households and livelihood

strategies, food spending and consumption and physical and financial asset ownership. This will help track changes in the economic situation of households. The questionnaire has been further developed to find out what the money generated in MED activities is spent on, and who controls it. DRA developed the questionnaire.

Sample:

- 60/60/60/survey: 60 members each from households with ill family members, with orphans, and with neither (control households), identified in the rapid scan survey
- Measuring the impact of MED training: use tool with MED trainees immediately after their training, and then repeat with same trainees after they have been running their businesses for 1 or 2 years.

Status:

- 60/60/60 survey: completed Oct 2000, report and publication available
- Baseline completed for seven groups of trainees, 1 year later survey completed for two groups, another 5 groups to be surveyed again in 2003. The first two groups can also be tracked after a second year.

3. **Risk behaviour survey**

Purpose: To measure sexual risk behaviour, and changes in risk behaviour
Sample: All MED trainees for three courses run in July 2002 (possibly others). Self administered.
Status: Questionnaire developed and survey to be done Sept 2002. Repeat with same trainees in 2003, after 1 year in business.

4. **General MED survey**

Purpose: To measure increases in knowledge and changes in the context around HIV: HIV positive living, Home Based Care and Orphans
Sample: Civil society, local institutions/groups and intervention target groups (possibly use LQAS sampling methodology)
Status: Rough draft of questionnaire

5. **PLA survey (Participatory Learning and Action)**

Purpose: To learn about the following from communities: family demographics, economic activities, livelihoods base, perceptions of family well-being, impact of illness, coping strategies, household workloads, and assets
Sample: 5 communities in Okhahlamba
Status: Completed July 2000, report available

6. Orphans survey

Purpose: To find out about the current well-being status of orphans in the project area (e.g. school attendance, physical needs, accessing of grants, needs of the family). Designed by Shalini Kapoor (Yale University)
Sample: Households that have orphans, identified in the Rapid Scan, and randomly selected
Status: Completed August 2001, thesis report available

7. Database: list of trainees and vulnerability classification

Purpose: To have a database of MED trainees that gives information about household vulnerability (households that have ill members, households that have orphans, households that have neither). Also monitors follow up.
Sample: Every MED trainee (trained either by HIV/MED project or OADP)
Status: 400 people on database will be updated regularly

Annex 5

A Needs Assessment Of Orphan Children And Their Caregivers In The KwaZulu-Natal Province Of South Africa

By

Shalini Kapoor

BA, 2000

A Thesis Presented to

The Faculty of the Department of Epidemiology and Public Health

Yale University

In Candidacy for the Degree of

Master of Public Health

2002

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Signature of Author

_____

Date

Abstract

The social institutions in the KwaZulu-Natal province of South Africa are increasingly in a state of disarray as a consequence of the HIV/AIDS epidemic. Of these institutions, traditional household units are especially burdened by the loss of productive family members and an overwhelming orphan crisis. It is estimated that by the year 2010, South Africa will have as many as 2 million orphans under the age of 15 (UNAIDS, 2000). Currently there is a scarcity of empirical data and relevant research on the socio-economic needs of orphans and their caregivers.

In order to address this paucity of data on AIDS orphans, a descriptive case-control, study was conducted in the Bergville/Okhahlama district of KwaZulu-Natal to assess the needs of orphan children and their caregivers as well as their awareness of government sponsored welfare grants and barriers in accessing the grants. Sixty orphan and 60 non-orphan households were randomly selected from among 584 households. Cases were defined as households with at least one child under the age of 15 who had lost his or her mother. Controls were defined as households with at least one child under 15 who mother was alive.

Results suggest a general lack of awareness of the existence of government sponsored welfare grants with only 3.8% of caregivers of orphan children receiving any kind of assistance. Only 50% of the children sampled could produce their birth certificate and immunization cards; documents that are crucial for applying for these welfare grants. Caregivers in both types of households also expressed a need for food, clothing and help with schoolwork. The information from this assessment will assist in designing service programs to better meet the needs of the orphan population and their caregivers.

Acknowledgement

I would like to acknowledge all the people who have been part of this project from its inception:

This research in South Africa was made possible by the generous contributions of the Downs International Travel Fellowship and Curtis D. Heaney Fellowship. I wish to express my sincerest thanks to my thesis advisors Drs Debbie Humphries and Michele Barry for their invaluable suggestions, guidance and support. To Monika Holst, Director of World Vision in Bergville, for being an awe inspiring presence constantly guiding and facilitating my work, for being an awesome neighbor in South Africa and for introducing me to the lovely cat Picallo. To Claire Kerry and Chris Gibson for their suggestions, feedback, support and help at various stages of the project. To Chris Desmond at the Health Economics and AIDS research Division who was my initial contact in South Africa and Anthea at Development Research Africa for their suggestions and help on the project. To the survey team -- Zanele, Bongi, PZ, Sabelo, Phumzile, Happiness and Nyadi who worked diligently and laboriously throughout the data collection phase. They made my trip incredibly memorable and a great learning experience. To the remarkable people I met during my travels in South Africa who made my stay comfortable, stimulating and unforgettable. A special thanks to Dr. Kaveh Khoshnood who has been a most delightful person to know from the time I started the program here at Yale and who continues to a great mentor and friend. His advice and support has been invaluable. To all my friends and family who have been unconditionally supportive of my work and me. You all have made this one of the most fulfilling experience of my life and motivated me to embark on my professional career in public health with great optimism and excitement.

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Chapter 1

Child Poverty and AIDS orphans: The South African government's response

1.1 Introduction

South Africa is characterized by extremes of wealth and inequality coexisting within a highly visible first-world infrastructure. The incidence of poverty is highest among the previously disadvantaged black population in rural areas and among female-headed households (USAID, 2000). Child poverty is extensive with an estimated 70% children living under the poverty line (Streak, 2001). The HIV/AIDS epidemic is further exacerbating child poverty and undermining progress in realizing child rights in South Africa. There has been a dramatic increase in the number of AIDS orphans[1] who are not absorbed by their extended families or communities and end up living on the streets or in orphan-headed households. The response of the government has been to develop a National Plan of Action with a view to prioritising children's interests in the national and provincial budgets (Streak, 2000a). So far, weak administrative capacity and budgetary constraints faced by the Department of Social Development (DSD) have thwarted the efforts of the government in mitigating the effects of the HIV/AIDS pandemic. Some of the policies implemented by the government have shifted the responsibility for the care of orphans to already marginalized and vulnerable communities without providing adequate financial or institutional support.

1.2 Demographics and Socioeconomic structure

[1] Children under 15 who have lost one or both parents to AIDS (Hunter 2000).

South Africa is categorized as an upper middle-income country by the World Bank, with an average per capita gross national product of USD 3160 in 1995 and with the second highest income inequality in the world (USAID, 2000; World Bank, 2000). The 1998 Poverty and Inequality report (May 1998), prepared for the South African government indicates that nearly 50% of the population is poor and 27% is "ultra poor" assessed against consumption-based income poverty lines. It identifies the most significant indicators of poverty as race[2], gender of the household head[3], educational level of household members, employment status, urban/rural divide[4], and provincial residence[5]. Thirteen per cent of the population (about 5.4 million people) lives in "first world" conditions. At the other extreme, 53 percent of the population (about 22 million people) lives in "third world" conditions. In this group only one quarter of households have access to electricity and running water; only half have a primary school education; and over a third of the children suffer from chronic malnutrition. About 50% of the households lack adequate housing, while 45% lack clean water and sanitation (World Bank, 2000).

The principle developmental challenge is overcoming the vestiges of apartheid[6], which for decades deliberately violated basic rights and denied opportunity to the

[2] 61% black, 38% colored and 5% of the Indian vs. only 1% of the white population are categorized as poor (Gilson and McIntyre, 20001)
[3] 60% female headed households are poor compared with 31% of male headed households (Gilson and McIntyre, 2001)
[4] 71% of the rural population is poor compared with 29% of the urban population (Gilson and McIntyre, 2001)
[5] Three of the nine provinces have poverty rates of 60% to 70% and account for 51% of the total poverty gap in the country despite being home to only 36% of the total population (Gilson and McIntyre, 2001)
[6] In 1910, the British founded The Union of South after their victory in the Anglo-Boer wars of 1899-1902. In 1961, the Afrikaner-led National Party (NP), in power since 1948, withdrew South Africa from the British Commonwealth. NP was responsible for laying the legal and political framework of apartheid, and this system of government marginalized blacks by excluding them from full participation in the political and economic system (World Bank, 2000). The multi-racial elections in 1994, shortly after the collapse of apartheid ushered in a black majority rule with Nelson Mandela elected as the president of the multi-party

majority population. Rising unemployment, high crime rate and weakness in the social delivery system are threats to the recent democratic gains of the country (USAID, 2000). Unemployment stands at 23%, and for most of those with jobs, productivity and wages are low. As a result, nearly 50% of South Africans live below the poverty line (USAID, 2000). Post apartheid census taken in 1996, estimates the total population of the country as 40.6 million. The black population represents 77% of this total, with whites, approximately 11%, 9% colored and 3% Indians making the balance[7]. One third of the South African population is functionally illiterate and less than half of the black students successfully complete primary school (USAID, 2000).

There is a strong racial and urban/rural dimension to child poverty. All indicators suggest that the suffering among black and colored children is greater than among White and Indian children (Streak, 2000). The difficulties of capturing the multi-faceted psychological and social experiences that compose poverty make it impossible to obtain comprehensive measures of poverty. The common practice is to fall back on money measures of expenditure to measure child poverty. In 1998, one such study estimated national and provincial poverty rates in South Africa for the age 0-5 using a poverty line of expenditure of R[8]176 (approx USD 17) per month per child. It found 60% of the children age 0-5 poor. This represents 25% of the entire population. The provincial child

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Government of National Unity (World Bank, 2000, CIA, 2001) followed by Thabo Mbeki: South Africa's second elected president in the year 1999. New democratic South Africa comes with a legacy of economic, health and health system inequities as a result of the apartheid policies.

[7] The terms blacks, white colored and Indians indicate a statutory stratification of the South African population in terms of the former Population Registered Act. In South Africa, the term colored refers to those of mixed race. The use of the term here does not imply the legitimacy of this racist terminology (Gilson and McIntyre, 2001)

[8] IUSD is approximately equal to 10 Rands, April 27, 2002

poverty estimates derived from this study provides the following poverty rates (Streak, 2000a).

Provinces in South Africa	**Poverty Rates (%)**
Eastern Cape	24%
Northern Province	16%
Mpumalanga	8%
Western Cape	5%
KwaZulu- Natal	23%
North West	10%
Free State	7%
Gauteng	5%

Table I: Poverty rates by provinces (Streak, 2000a)

These provincial child poverty estimates reveal the unequal distribution of poor children. KwaZulu Natal[9] and Eastern Cape bear the highest burden. Approximately 73% (age 0-5) live in four provinces: Eastern Cape, KwaZulu-Natal, Northern Province and North West (Table I, Streak, 2000a).

More children are being pushed into, and deeper into poverty, as a result of HIV/AIDS. The number of children that have lost either one or both parents to AIDS has been on the rise. It is estimated that by 2010 there will be at least 2.6 million orphans under the age of 15 (Table II, Adam 2000) This poses clear challenges to the welfare sector due to the increased demands on welfare grants (Adams, 2000) There is a dramatic increase in the numbers of children that are not being absorbed by and cared for by the state or community after having lost their parents. Instead they are being forced onto the streets or living in child headed households. The number of children who are unable to

[9] According to the Human Development Index (HDI), which is a composite index of life expectancy at birth, educational attainment and living standards, these are also the poorest provinces. The values of HDI range from 0-1 with low values flagging low levels of development. KwaZulu-Natal has a HDI of 0.60 which is among the four lowest in HDI scores in the provinces (Streak, 2000a)

attend school and or have to work to supplement household income due to HIV/AIDS illness or death in the family is on the rise (UNAIDS 2000, Streak 2001b).

	Total child population under 15 years	Orphans as a result of all causes	Orphans as a % of child population under 15
1990	13,769,200	10,343,60	7.51
1995	14,825,130	13,338,58	9.03
2000	15,542,260	18,062,78	11.62
2005	15,957,889	22,643,64	14.19
2010	15,623,243	26,352,05	16.87

Table II: Number of Orphans from all causes in South Africa. (Adam, 2000)
Source: South African National Council Child and Family Welfare, 1999; Adams, 2000)

In order to understand the provisions of the government for the children of South Africa, it is important to note the complexities of the political and bureaucratic organization of the government structures.

1.3 Political Organization: National and provincial Government

South Africa has nine provinces and provincial assemblies, which are elected by proportional representation and vary in size from 30 to 80 members depending on the population. Each province has a premier, elected by the provincial assembly, who presides over an executive council of no more than 10 members. Matters relating to agriculture, education, housing, police (in part), tourism, regional planning, urban and rural development, and welfare services are areas of joint national and provincial control (CIA, 2000). While the provinces are responsible for spending on welfare services, they are largely dependent on funding from the central government (Idasa, 2000a). At the local level, currently, there is a single tier of government over most of the country, but a two-tier system exists in some metropolitan areas. The new constitution allows provinces

to assign any of its legislative powers to a municipal council in that province (CIA, 2000)[10].

1.4 National policies: Growth and Reconstruction in the post-apartheid era

While political participation has greatly improved with the establishment of a democratic government, South Africa's economic transformation has clearly lagged behind. In the post-apartheid era, the government mandate to redress inequality has been clear. Through the Reconstruction and Development Program (1994), the African National Congress (ANC), prioritized health to affect broader social and economic development (Gilson and McIntyre, 2001). The government's focus has been to control the deficit while stepping up spending on social programs to combat inequality (World Bank, 2000). There is, however, a growing concern about the government's ability to achieve its socio-economic goals.

The government's current macroeconomic framework, GEAR, (Growth, Employment and Redistributive Strategy) on economic and social change is highly contentious although it seems impossible to undertake a full analysis of its impact just yet (Gilson and McIntyre, 2001). The GEAR has been controversial in that it is known to ignore the fundamental need to transform the economic structures, particularly the segmented labor market inherited from the apartheid era. GEAR has not explicitly tackled the broader issues of inequity and welfare -- in fact, some critics are convinced that those likely to be hit the hardest by labor market flexibility are women because of

[10] South Africa's first fully elected, nonracial councils came into being in 1995 and (in a few areas) 1996. These were regarded as transitional councils that were replaced by municipal councils in 1999 under the new constitution. The final form and categories of the municipal councils have yet to be decided (CIA, 2000).

wage moderation and huge income differentials. Analysts suggest that these macroeconomic policies promoting wage restraint and flexible job markets are likely to create a divide between a core pool of organized labor able to demand and improve working conditions and an increasingly disorganized segment of labor (especially women in the informal sector), to negotiate improved wage levels, working conditions and social benefits. Additionally public sector restructuring involving employment cuts is likely to hit both the poorest provinces and women the hardest. Thus GEAR could have the potential to exacerbate inequality within the society (Gilson and McIntyre, 2001). Just as the government's response to poverty and inequality has been the introduction of the GEAR, it has responded to the HIV/AIDS crisis through the national HIV/AIDS strategy and through some reforms in the social development policies.

1.4.2 The National AIDS/HIV/STD Strategy (2000-2005)

This initiative is funded by the Department of Social Development (DSD)[11] budget and allocations from National Integrated AIDS Plan (NIP), 2000. NIP is an intersectoral national government plan for responding to HIV/AIDS. NIP focuses on three programs and is jointly delivered by the health, education and welfare sectors. Separate from the regular budget process, the NIP funding is a top- slice from the National Revenue Fund set aside as a national priority (Hickey, 2001). Although the NIP is in its early stages, the provinces are being given a larger role in service delivery (Hickey, 2001). The three programs are Life Skills Program, Voluntary Counseling and Testing (VCT), and the Community and Home Based Care and Support (CHBC). Initially the bulk of the resources were allocated to the Life Skills programs and HIV/AIDS training in primary

[11] Department of Social Welfare was renamed the Department of Social Welfare in 2000

and secondary schools but more recently the policy emphasis has begun to shift towards treatment and strengthening the CHBC component of the program. The CHBC, which is the most relevant in alleviating child poverty, is a complicated process subject to distribution of conditional grants by the national Department of Health and the Department of Social Development. The sustainability of the NIP in terms of funding is a looming unanswered question. The conditional grants are given to provinces through a business plan process. Provinces submit business plans for each program that are reviewed and approved by officials in the provinces and officials in the provincial department and national department and ultimately dispensed by Department of Health and the Department of Social Development. So far this has fraught with difficulties: slow approval process, delayed release of funds, capacity problems at the provincial level in developing business plans (Hickey, 2001). The NIP is a young program and continues to struggle to build provincial capacity for HIV/AIDS programs in addition to finding a sustainable strategy for funding in the future. Although this is characteristic of new programs, the complications are exacerbated by the intersectoral and national/provincial coordination required on the urgent issue of HIV/AIDS.

The government has also set up the Joint Parliamentary Monitoring committee on improving the quality of care for children, youth and disabled persons and aims to monitor the implementation of government policy of the aforementioned constituencies. According to the National Plan of Action for Children, the government will deliver its promises to poor children by streamlining children's interest in national and provincial budgets (Streak, 2000a). The majority of funding to deal with the impending HIV/AIDS

crisis is expected to come from the provincial and DSD budgets. This would require significant reprioritizing of the existing departmental priorities.

1.5. Current Welfare provisions for children through the Department of Social Development

The current social security system is fragmented and non-comprehensive, with many groups of children falling through the gaps. Poor children between the ages of 7 and 18 are not catered for, nor those infected or affected by HIV/AIDS. Many children such as street children and child-headed households cannot access the grants. Generally, social assistance is limited to cash transfers, and does not incorporate a range of other possibilities, such as fee waivers, subsidization, vouchers and tax reductions (ACESS, 2001). Table iii below shows the welfare provisions available through the Department of Social Development.

Grant	Eligibility criteria	Documents required
Child Support Grant R110 per month per child)	• Person (does not have to be a relative) looking after a child less than 7 years of age (up to a maximum of 6 children) and has an income less than R800 per month. • Caregiver must not be in receipt of any other grants on account of the child/children • Legal adoption of the child is not necessary	• Child's computerized birth certificate • Proof of income: (salary slips, slips of rent received, receipts for material possessions or affidavit to prove unemployment status) • ID book of caregiver • ID number (6 digit bar-coded number) of child • Immunization Card
Foster Care Grant (R 410 per month per child)	• Guardian of a child <18 yrs of age who has lost both parents. • Caregiver must have legally adopted the child • Caregiver has to qualify a means test • Ineligible if they receive total care in a state institution such as state old age homes, prisons psychiatric hospitals or care and treatment centers because hey receive food and shelter.	• South African identity document • Death certificates of both parents • Marriage certificate of parents • Computerized birth certificate of Child • Court evidence of legal adoption • Proof of income and assets (salary slips, slips of rent received, receipts for material possessions etc.)

Contd… **Grant**	**Eligibility Criteria**	**Documents required**
Disability Grant (R570 per month per child)	• Any adult with a medical condition that prevents them from functioning normally	• Medical certificate to prove disability • Proof of income and assets (salary slips, slips of rent received, receipts for material possessions) • Proof of marriage certificate • ID Book
Care Dependency Grant (R 410 per month per child)	• Any guardian (parents or foster parents) caring for a child between the ages of 2 and 28, where the child has a significant medical problem which causes disability	• **Medical certificate** • ID of mother/guardian • Birth certificate of child • If single parent, proof that the other parent cannot contribute financially.

Table III: Current provision of welfare grants from the Department of Social Development (DSD, 2000; Moll *et al.*, 2000)

1.6 Reform within the Social Development Sector

One of the biggest challenges facing the DSD is to attain the social development vision articulated in the White Paper for Social Welfare, 1997, without jeopardizing the fiscal sustainability of DSD's declining budget (Adams, 2000). It is evident that the number of people who will become dependant on the state for support will increase dramatically as HIV/AIDS decreases the health and productivity of parents/traditional breadwinners. The figures in Table IV show the rough estimates of the residential status of children orphaned by HIV/AIDS related death of their parent(s) in 2000. However, this data is by no means inclusive since there are currently no registers of orphaned children maintained in any of the provinces and these estimates are potentially conservative.

In foster Care	35%
In residential care	0.25%
Adopted	0.1%
Family/Community care	64.65%

Table IV: Rough estimates of the residential status of children orphaned by HIV/AIDS related death of their parent(s) in 2000

The increase in the number of orphans has been marked by a reported decrease in available places for children in children-homes by 59% (Adams, 2000). This clearly shows an increased reliance for care of children on non-traditional institutions. Some of the recent in the social grant system in response to HIV/AIDS are outlined below:

1.6.1 Reform of the Disability grant (DG)

Previously, two medical doctors (one a district surgeon) had to certify a potential candidate's state of health or fitness for work. The new disability strategy replaced the medical doctors with a panel consisting of several health professionals, depending on the nature of disability. As a result of this re-registration, the number of beneficiaries declined by approximately 3% (Adams, 2000).

1.6.2 Reform of the Child Support Grant (CSG)

In 1998, the state introduced the CSG to replace the racially biased State Maintenance Grant. The CSG is targeted at 3 million of South Africa's poorest children. However due to the weak administrative capacity and budgetary constraints faced by provincial DSDs, the take up rate of the CSG has been very low. The grant is paid to a child's primary caregiver for a maximum of 6 children under the age of 7. The fact that the primary caregivers, rather than just biological parents, are given access to the CSG is a positive feature since the majority of children orphaned by HIV/AIDS are in family or community care and this ensures their access to the grant (Adams, 2000). Problems with the grant include: 1) Children above the age of 7 are excluded; 2) Household taking in

multiple children are limited to 6 children; 3) Eligibility criteria include a birth certificate to verify age, and this is unavailable for these orphaned children.

1.6.3 Reforms of the Foster Care Grant (FCG)

The FCG provides for children who are placed in the care of a person who are is his or her parent[12]. Assessing the grant involves court proceedings and a means test. The foster child is ineligible if the income of the caregiver is more than double the annual amount of a foster child grant (Adams, 2000). As seen in the table 3 above, only, 35% of the children are formally adopted and this shows a potentially huge demand for FCG in the future as the number increases (The number of orphans is expected to increase to 2.2 million by 2005, even by a conservative government estimate (South African Council for Child Welfare, 2000 as reported in Adams, 2000)). The FCG amount is significantly higher than the CSG and seems more beneficial for the caregiver; the only caveat being the judicial process and the expense involved which the applicant incurs. This keeps a lot of caregivers who are eligible for FCG from receiving it (Adams, 2000).

1.7 Unspent poverty alleviation funds:

Overall, from the 2000 budget it is apparent that there are several spending initiatives that contribute modestly to reducing child poverty. Nonetheless, it is noted that the level of expenditure on programs to reduce child poverty is insufficient and that in the context of high unemployment and jobless growth, the budget does not do enough for the poor children. (Streak, 2000). Of concern is the fact that the bulk of the expected additional

[12] In terms of Chapter 3 and 6 of the child care Act, 1983 (Act No. 74, 1983) and Social Assistance Act, No. 59, 1992

costs of the impact of HIV/AIDS will have to be addressed out of the provincial equitable share allocation and the existing budget is insufficient to realize the target goal. Despite the dire need for financial support, it is ironic that DSD failed to spend R203 millions in poverty relief funds in its developmental role for poverty alleviation during 1999-2001. The main reason is the complexity of transfer mechanisms from the Department of State expenditure via the department of Social Development to the Independent Development Trust and only then to the targeted projects. In addition to time delays, lack of effective monitoring capacity in the Welfare department slows the process and results in unspent poverty funds. Even while the money is available and the need is great, lack of effective delivery mechanisms and can dampen the will to affect change (Ntenga, 2000). Due to the chronic under spending, the design and implementation of poverty relief projects were relocated to the provincial department in an effort to decentralize. However the projected poverty relief allocation for 20001/02 has been reduced significantly. The Department has decided to refocus expenditure on the poorest provinces but it is a matter of great concern that the allocation to poverty programs in provinces in need of money is steadily declining in spite of support from the national department (Adams, 2001) due to lack of capacity and poor delivery mechanisms at the provincial level.

1.8 Evaluation of the response of the Department of Social Development: Service gaps and problems with program implementations

The response of the Department of Social Development to the orphan crisis has shifted the responsibility for the care of orphaned children to already marginalized and vulnerable communities without providing adequate financial and institutional support.

To argue that such inadequate and unresponsive policies could, in addition to creating orphan headed-households, contribute to child prostitution, criminal activities and higher HIV/AIDS rates is by no means an over-speculation (Adams, 2000). An inadequate response to HIV/AIDS could jeopardize some of the progressive initiatives like free education, juvenile justice projects and protection of the girl child (Adams, 2000).

The National AIDS/HIV/STD strategy for 2000-2005 is grounded in a strong preventive model as a response to the HIV/AIDS pandemic (Adams, 2000). While this is necessary, the model fails to address the stigma attached to AIDS orphans. Results of a recent community survey in South Africa indicate that only 28% people felt that relatives should take care of AIDS orphans and 62% felt that care for orphans is the responsibility of the government and not of the community (Adams, 2000). Orphans older than 7 years suffer a greater risk of abandonment due to the lack of governmental support. This claim is supported by data showing 67% abandonment of orphans over the last 3 years (South African National Council on Children and Family Welfare, 1999). Promoting family care in the absence of adequate financial support and changing family structure seems counterproductive.

Chapter 2:

The legal framework: South Africa's obligation towards children

An international human rights framework as well the constitutional provisions in South Africa provide a general framework for understanding the obligation of the State with regard to the children made vulnerable by the AIDS epidemic.

2.1.1 The Right to Social Assistance

In South Africa's new constitution, Section 27 (1)(c) provides that *"everyone" has the right to have access to social security, including, if they are unable to support themselves and their dependants, appropriate social assistance*. This is a general right, which is clearly intended to extend to the child. This right is limited by the available resources of the State and must be progressively realized.

2.1.2 The Right to basic care and services

In addition to Section 27, the Constitution recognizes the specific right of the child to basic nutrition, shelter, basic health care services and social services. These rights are not subject to the State's available resources and must therefore be realized immediately.

The rights contained in Section 28 are a reflection of a number of provisions under international law, most notably contained in the Convention of the Rights of the Child (Convention), which was signed and ratified by South Africa in 1995. Other relevant treaties, which are binding on South Africa, include the African Charter on the Rights and Welfare of the Child (the African charter), signed and ratified in 1996 and the International Covenant on the Civil and Political Rights (ICCPR), also signed and ratified in 1996. The International Covenant on Economic, Cultural and Social Rights (ICESCR) was signed in 1994 and is expected to be ratified in the near future.

Although not legally binding a number of other international instruments reinforce the rights under discussion and these include the Universal Declaration of Human Rights (UDHR) (1948), the Declaration of Social and Legal Principles Relating to the Protection and Welfare of Children (1986), the United Nations (UN) Standard Rules on the Equalisation of Opportunities for People with Disabilities (1993) and the UN Guidelines for the Protection of Human Rights in the Context of HIV/AIDS (Resolution 33)(1997).

A number of principles can be drawn from these agreements that aid in interpreting the State's constitutional obligations to provide social security for children.

2.1.3 The right to "special" care and assistance:

It is a general principle under international law that children have the right to "special" care and assistance, (Article 25 UDHR). In addition, Article 3.2 of the Convention also recognizes the general rights of the child to such protection and care as is necessary for his or her well being. They are reflected in section 28(2) of the Constitution, which provides that *"a child's best interests are of paramount importance in every matter concerning the child."*

2.1.4 The right to social security and an adequate standard of living*:*

Article 26 of the Convention on the rights of the child recognizes the right of every child to benefit from social security and this is followed in Article 27 by recognition of every child's right to a standard of living which is *"adequate"* for that child's physical, mental, spiritual, moral and social development. State parties must take appropriate measures to assist parents and others to implement this right and shall, in case of need, provide material assistance with regard to nutrition, housing and clothing (Article 27(3)).

Again, these rights are reflected in the Constitution. Section 27 provides *"everyone"* with the right of *"access to*" social security and, more specifically, section 28 (1)(c) confers an unfettered right to "*basic*" nutrition, shelter, and basic health care services and social services. Although the standard of "*basic*" services is arguably lower than "*adequate*" services stipulated under the Convention, the right is nonetheless significant because it is <u>not</u> limited by the *"available resources"* of the State. This is in recognition of the "*special*" status of the child in terms of the care and protection to be afforded.

2.1.5 The right to medical care

Every child has the right to the enjoyment of the *"highest attainable standard of ... health"* and facilities for the treatment of illnesses and rehabilitation of health. The State must take *"appropriate"* measures to ensure, amongst other things, the provision of necessary medical assistance and health care to all children, to combat diseases and malnutrition and to diminish child and infant mortality (Article 24 of the Convention on the rights of the child, Article 14 African Charter). The ICESCR imposes an obligation to the State to take steps necessary for the reduction of infant mortality, the healthy development of the child and the prevention, treatment and control of epidemic and other diseases (Article 12).

2.2 Rights specific to Children in the Context of HIV/AIDS

UN Guidelines for the Protection of Human Rights in the Context of AIDS (Resolution No.33, 1999) establishes basic minimum rights for all people living with HIV /AIDS and calls for the widespread availability of adequate measures of prevention and care and the strengthening of anti-discrimination laws to protect people living with HIV/AIDS. The Guidelines were followed in 1999 by Resolution No.49 which explicitly links AIDS deaths with levels of poverty and the absence of appropriate measures of prevention, treatment and care. The Resolution endorses the 1997 Guidelines and concludes that effective strategies for prevention, treatment and care are critically needed.

While neither is legally binding, these two documents mark a growing recognition by the United Nations of the existence of an individual's rights in the context of HIV/AIDS and are to be applied equally to adults and children alike. Although neither document expressly recognizes a special right to social assistance for people living with HIV/AIDS, there is a clear recognition of the right to adequate treatment. The repeated links between poverty levels and rates of HIV/AIDS infection demonstrate the importance of the provision of social assistance and/or medical care as an essential component in this right.

2.3 Recognition of the Status of the Family

Many international instruments recognise the importance of the family as the natural and preferable environment for the development of the child. This is followed by a recognition that States have an obligation to provide families with such assistance as is necessary to enable them to provide such an environment (Article 23, ICCPR, Declaration of Social and Legal Principles relating to the Protection and Welfare of Children).

2.4 Limitation of the Right to Social Assistance

The rights specific to children set out in Section 28 of the Constitution are not subject to the available resources of the State and must therefore be addressed immediately. They can be regarded as the minimum core, the essential immediate component, of the State's obligation to provide social assistance to children.

Section 27 and the obligations arising under international law are subject to progressive realization in accordance with the available resources of the State. The question of available resources is therefore critical when deciding what measures the State must take to comply with its duties. However, recent jurisprudence in South Africa together with policy indications from the United Nations suggest that it is not acceptable simply for the State to argue, even in good faith, that it does not have the financial resources to further the realisation of the rights under discussion. In relation to the right to the highest attainable standard of health, the UN Committee on Economic, Social and Cultural Rights (ECSCR) has recently noted that if resource constraints rendered it impossible for a State to comply fully with its obligations under the ECSCR then it had the burden of justifying that every effort had nevertheless been made to use "*...all* available resources at its disposal" (14th General Comment, 11/05/2000).

2.5 The State's policy to provide social assistance for children with HIV/AIDS

There is some general recognition at the government level of the need to take measures to address the impact of HIV/AIDS and the importance of social assistance as a measure of poverty alleviation. Specifically, the acknowledgement of the link between poverty and HIV/AIDS is a significant step forward as it follows that short-term poverty

alleviation can have a positive effect on the long-term costs of providing for individuals infected with or affected by HIV/AIDS. Recent policy documents like the White Paper on an Integrated Disability Strategy, White Paper for Social Welfare 1997, 10 Point Plan, National Strategic Framework for Children Infected and Affected by HIV/AIDS and The National Plan of Action, Five Year Plan signal a commitment to improved care and treatment and promised measures to reduce the impact on families of caring for an HIV/AIDS infected family member.

2.6 United Nations evaluation of current social assistance provision for children in South Africa

At the 23rd Session of the UN Committee on the Rights of the Child, the UN Committee considered the extent of South Africa's compliance with its international obligations and encouraged the State to continue its programme of legal reform, including expansion of the child care system. It made a number of specific recommendations in this regard:

2.6.1 It noted with concern that "*insufficient measures have been taken to ensure that all children are guaranteed access to education, health and other social services. Of particular concern are certain vulnerable groups of children, including black children, girls, children with disabilities ... children working and/ or living on the streets ....*"(para 19).

2.6.2 It specifically recommended that the State expand its Child Support Grant programme or develop alternative programmes to include support to children up to the age of 18 years who are still in school (para 24).

2.6.3 It recommended that the State increase its efforts in providing support to discourage the abandonment of children and expressed its concern about the insufficient number of alternative care facilities available (para 25).

2.6.4 It recommended that the State allocate appropriate resources to improve the health situation of children including facilitation of greater access to primary health services, reducing the incidence of maternal, child and infant morality and

preventing and combating malnutrition, especially in vulnerable children (para 29).

2.6.5 It expressed concern at current inadequate protection, programmes, facilities and services for children with disabilities and recommended the State consult United Nations International Children's Education Fund (UNICEF) and World Health Organization (WHO) (para 32).

2.6.6 It recommended that the State should identify strategies to address the continued discrimination experienced by children and adolescents infected with HIV/AIDS (para 31).

2.6.7 It recommended that the State take necessary measures to reduce and prevent child headed households and introduce adequate support mechanisms when they do occur (para 22).

2.6.8 It recommended greater inter-ministerial co-ordination between the Ministries responsible for the implementation of the Convention (para 12).

2.6.9 It encouraged the State to pay particular attention to the full implementation of the Convention **"***by prioritising budgetary allocations and distributions to ensure implementation of the social, economic and cultural rights of children, to the maximum extent of available resources"* (para 17).

The State, in its response, welcomed the Committee's constructive criticism and assured the Committee that it "remained fully committed to fulfilling many of the recommendations outlined by the Committee".[13].

[13]Statement by the South African Delegation, Geneva, 12 April 2000, Item 13, page 2

Chapter 3

Project site description, study objective and hypotheses

3.1 Project site description

The Bergville District is located in the Western KwaZulu Natal and comprises the Bergville and Okhahlamba West magisterial districts. It is at the foot of the Draakensberg mountains and shares a provincial border with the Free State and an international border with Lesotho. The area is predominantly rural characterized by commercial farming, tribal land and black freehold land. The town of Bergville is the locus of activity in this region. A baseline household study conducted by the Health Economics and AIDS Research Division (HEARD)[14] in collaboration with World Vision[15] in 2000 surveyed 781 households in this region and found that most households have access to few resources beyond the most basic needed to survive. The vast majority (over 90%) of the people live in traditional house structures made with materials like mud, brick and dung (dugga). Less than 10% of households have a permanent house in the brick and block style and the remaining households live in shacks made from plastic, cardboard and/or corrugated iron. Only 39% have direct supply of clean piped water whereas the remaining 61% of the households access water from wells, boreholes, dams, flowing streams or springs from far away places. None of the toilets in these areas are flushing toilets. Approximately 15% of households do not have a toilet attached to the homestead and about 85% of households use pit toilets (dug in the ground), which are poorly ventilated. All toilets, where they existed were located outside of the homestead and refuse disposal took place at home with approximately half of households burying it and the rest burning it on site.

Additionally, only one third of households surveyed were connected to an electricity supply. The main energy source used for cooking is wood, which is employed by almost two thirds of households. The other significant source of cooking energy is paraffin. Heating is an issue in the Bergville area in winter and over 80% used wood as the main heating source. In terms of financial savings, only 39 bank savings accounts are held by the 1650 people in the 178 households, which are shared equally between males

[14] HEARD, University of Natal, Durban, South Africa.
[15] World Vision, Bergville, South Africa.

and females. Stokvels or community savings groups are held by 24 out of 178 households with females being the instigator in 22 out of 24 of those households. With little individual or household interaction with banks it is unsurprising also that the number of cash loans held by members of all households were very low. More commonly credit is obtained directly when purchasing consumer goods with approximately 20% of households having hire purchase commitments. Informal credit arrangements are also a source of borrowing for about 10% of households (HEARD, 2001)

3.2 Study Objective

There is a paucity of data regarding the residential status and requirements of orphans and their caregivers. The purpose of the study was to assess the basic needs of children (under the age of 15 years) and their caregivers in these communities as well as their awareness of the federally sponsored welfare grant. Effort was made to understanding the barriers to accessing social welfare assistance from the state. The information from this assessment is intended to assist in designing service programs targeted to the needs of these children and their caregivers.

3.3 Study Hypotheses

3.3.1 Orphaned children have less access to physical resources like food, bedding, clothing; medical care, education than the children in households with no orphans. Non-orphan children living in the same house as orphan children (referred to as Norphans for the purpose of this study) are also lacking in material comfort compared to the children with parents (Controls).

3.3.2 Households with orphans have greater awareness and uptake of social welfare assistance provided by the provincial and federal government.

Chapter 4

Methods

4.1 Study Design

A case-control, descriptive study was conducted in the tribal wards of Amazizi and Amagwane and 11 settlement areas of the Bergville/Okhahlama district of KwaZulu Natal province of South Africa.

4.2 Sampling method

Sixty orphan households (case) and sixty non-orphan households (control) were randomly (via computer random number generation) selected from among 584 households identified in a previous rapid household scan[16] study conducted through a collaboration between World Vision, HEARD and Development Research Africa[17]. This random selection ensured a representative and probability-based sample of households in the area. A control group was also deemed necessary to make it possible to distinguish between negative outcomes that may be common to the area and outcomes most likely to be a result of having taken in orphaned relatives. It was assumed that the majority of orphans would be from parents dying of HIV/AIDS, but we did not ask about parental cause of death. The study population was separated into two groups:

1) Orphan households: These were defined as households with any children under 15 who had lost their mother. Orphan households may contain Norphans as well.
2) Control Household: These were defined as households with children less than 15 years of age, whose mothers were still alive.

A maximum of two orphans and two norphans children in the 'orphan households' and two children in the control households were interviewed for each household identified. Multiple children within each household were interviewed to increase the probability of a more representative sample in terms of age and gender. In houses with multiple children, subjects (orphans, norphans and controls) were selected by a method of random selection by drawing two names from a hat for each category.

[16] The rapid household scan is a grid that records some demographic, economic, morbidity and mortality information of the households that live within the defined population

4.3 Informed consent/confidentiality

Respondents were informed of the reason for collecting information -- namely that this information would help their community leaders understand the needs of children and they're to improve the general well being of the child and ensure the protection of their rights. They were made aware that participants would not directly benefit by participating but that their participation would be valuable for the benefit of the community. They were instructed that they could refuse to answer or terminate their participation at any point in the interview. Interviews were administered after consent was given.

No full names or addresses were recorded on the questionnaire and unique identifiers were used for data entry to preserve the confidentiality further.

4.4 Study Instrument

The study instrument was developed by the researcher and administered after incorporating several modifications by the team-workers. Questionnaires, originally designed in English were translated to Zulu and then translated back to English. Seven trained staff members subsequently administered these questionnaires to the participants. Mock interviews were held during the training period and the questionnaire was pilot tested in four households (2 orphan and 2 control households), and necessary changes were made. These four houses were not used in the analysis. All responses were coded in English and for those responses recorded in Zulu were translated into English.

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[17] DRA. Durban, South Africa

4.5 Data Collection

The questionnaire was used to ask participants questions[18] about

A) Household structure: number of members living in the house, age (rounded to the nearest year) and gender composition, number of rooms in the kraal (house or household compound). For ages mentioned as a range, the average age was entered (e.g. For age range of a member recorded on the questionnaire as 40-50 years, for the purpose of the analysis, the age entered for analysis was taken to be 45)
B) Information on literacy and employment status of the primary caregivers.
C) Information on how long ago the child was orphaned and whether the child had moved since the death of the mother.
D) Education status of the child and reason for discontinuity of schooling if applicable.
E) Information on physical material resources available to the child—food, clothes, shoes, beds and blankets.
F) Information on the possession of a birth certificate, Road to health card (immunization card).
G) Labor demands on the child at home and for money.
H) Information on the financial support provider's relations ship to the child with respect to providing the child's education, medical services, physical and material needs.
I) Whether the household had to sell assets as a coping strategy employed by the household members to enable the care of the orphan child.
J) Perceived needs of the caretaker: food, clothes, beds/blankets, school fees, help with schoolwork, emotional support, transportation, medical care, etc.

4.6 Data Analysis

The data was entered in EPIINFO 2000. Univariate analysis for continuous variables and frequencies and chi square estimates for statistical significance testing was performed for categorical values using SAS v8.

[18] Please see Appendix 3 for questionnaires used to interview Orphan and Control households.

Chapter 5

Results

From the original planned sample size of 120 houses (total), 56 orphan households (for a total of 76 orphans and 50 norphans) and 45 control households (for a total of 80 controls) were interviewed. This does not include those interviews that were incomplete or had other problems with data integrity. Four houses that were used to pilot the test were not included in the analysis because some questions were changed or worded differently in the final questionnaire. Two houses initially identified as "orphan households" did not have any orphans living in the house and three households, which were identified as "Control households", had taken in orphans. Nevertheless these households were interviewed but excluded from the analysis

5.1 General characteristics of the household:

The results indicate that children in the three groups (orphans, norphans and controls) live in households with similar composition of members and rooms. The average number of members in the household ranged between eight and nine in each household and the number of rooms in the household compound (kraal) ranged between six and seven (Table 1- 2).

5.2 Child Information

The age and sex of the children in all three groups of the sampled population were very comparable. The gender ratio was similar among the orphan (44% males and 56% females), norphans (49.06% males and 50.94% female) and control (45.57% males and 54.43% females) populations (Table 4). The mean age of the orphan children (8.773, sd= 3.818) was slightly higher than the norphan (6.0188, sd= 4.4828) and controls (6.88607,

sd= 4.098) (Table 3). Fewer orphan children's fathers were alive (48.7%) compared to Norphans (80%) and controls (76.9%) (Table 28) and the three groups were significantly different. Most children above the age of six in all three categories were enrolled in school and helped at home with household work and in fetching water.

5.3 Caregiver Information:

Women were the dominant primary caregivers for all three populations studied (orphans, norphans and controls). Orphans and controls have higher male caregivers (19.7 and 17.9% respectively) compared with only 9.6% male caregivers for norphans (Table 5).

Orphans had older caregivers than the caregivers of norphans and controls. The mean age of the caregiver for orphans was 53.75 (sd= 12.5; range of 25-85) compared to 46.46 yrs (sd= 12.5; range of 19-77) for norphans and 43.64 years (sd= 12.5; range of 19-73) for controls (Table 6).

Caregivers of norphan children reported higher rates of literacy compared to caregivers of orphan and control children. A "literate" caregiver was one who could read a prepared script in Zulu. Table 7, indicates 71.2% literate norphan caregivers compared to 51.3% orphan and 61.5% control caregivers. Only 37.3% of caregivers of orphan children were employed compared to 32.1% norphan and 41.3% control caregivers (Table 8)

Literacy, employment status and sex of the caregivers were not significantly different from each other in the three groups (Table 9, where p-values were > 0.05). Grandmothers were more likely to be providing care for orphans (65.8%), compared to 38.4% norphan and 28.5% controls (Table 10, 11)

5.4 Birth Certificates and Road to Health cards (Immunization card)

Only 30% of the orphans, 40.4% norphans and 45.5% controls reported having birth certificates (Table 12). There were no significant differences between the three groups (p-value = 0.66) (Table 12, 15). The rates of having immunization cards (referred to as Road To Health Cards) were higher than that of having immunization cards in all three groups but orphans had the lowest rates of possession of cards (Table 13). When asked to show the card, only 50% caregivers of orphans compared with 66% norphans and 63.5% controls could comply (Table 13). When asked whether the child was fully immunized for his or her age, more caregivers did not know the answer for orphans than for the other two groups (Table 12). More children in the norphans and control groups were immunized (self reports) than orphans.

The caregiver's perception of whether the child was fully immunized for his or her age was significantly different between the orphan and norphan populations (p-value = 0.0308) and between the orphan and control groups (p-value of 0.0120). These groups were also significantly different from each other with respect to having Road to Health cards (Tables 15, 16a-c).

5.5 Availability of basic material resources for the child

Table 17, illustrates that all three groups reported not having a mattress. Only 17.1% orphan, 11.5% norphans and 13% controls slept on a mattress. A higher percentage of orphans reported having blankets than norphans or orphans. While all the norphans had an extra set of clothes, only 79.2% of controls and 84.2% of controls reported having extra set of clothes. Shoes were by and large, available to only half of the children

interviewed (56.6% orphans, 55.8% norphans and 70.1% controls) (Table 17a, b). Overall there were no significant differences observed between the three groups with respect to the availability of physical supplies available to them (Table 17 b, c), except with respect to the availability of extra set of clothes.

5.6 Needs of the caregivers to look after the child better

When caregivers of all three groups were asked which needs they were struggling to provide for the child, most caregivers listed food, clothes, medical care for the child and school supplies (Table 18).. Caregivers in all three groups felt that receiving help in the form of clothes and food would be helpful (Table 18). Overall controls were less likely to be struggling with such needs as food and clothes About 52.6% control houses, compared with 17% norphan and 43% control caregivers felt that receiving help with schoolwork for the children would be helpful in looking after the child better.

Generally, the needs of the caregivers of controls and norphans were mostly similar except that more controls than norphans needed help with schoolwork (Table 18). Statistically, there were significant differences between the three groups with respect to the needs of school fees and clothes. When stratified further by comparing two groups at a time, these needs were significantly different between orphan and norphans. The differences between norphans and controls were not statistically significant between norphans and controls. There were significant differences between orphans and controls with respect to school related expenses (Tables 18-21)

5.7 Awareness or receipt of any government sponsored grants

When asked whether the caregivers were receiving assistance through any government-sponsored grants, 13.8% of the controls replied in the affirmative whereas only 5.7% norphans and 5.1% orphans said " yes" (Table 22). None of the caregivers of the orphans were aware of Child Support grant, Care Dependency grant or the disability grant. About 17% of the norphan caregivers had heard of the Child Support Grants compared with approximately 19% of the controls. On stratifying the results for each group compared with the other, there was a significant difference in the awareness of grants between orphans and controls ($p= 0.0143$) (Table 25). The up-take of these grants was quite poor with only 5% orphan and norphan caregivers receiving any State assistance (including Social pension), compared to 13.8% controls. Only 3.8% orphan households were receiving foster care grant.

Chapter 6

Discussion

Household structures are similar for both "orphan" and "control" households with and average of eight to nine members in each household sharing approximately six to seven rooms. These results are consistent with the rapid baseline household study conducted by the Health Economics and AIDS research at the University of Natal (HEARD, 2000). Traditionally the burden of care is on women in these areas and the results from this study concur with that (Table 3). While the literacy rates were not significantly different between the three groups, it is worth mentioning that a higher percentage of caregivers of norphans and orphans were literate, and more aware of welfare grants than caregivers of orphans. It is also interesting to note that orphan children were cared for by older caregivers who were less literate than caregivers of controls or norphans. Grandmothers (maternal or paternal) were more likely to be the primary caregivers for orphans whereas norphans were more likely to be cared for by their mothers who were usually younger. From the present analysis it is not clear if awareness of grants is associated with higher literacy or lower age of the caregivers.

The general availability of birth certificates in these regions is low, with only 30% of the orphans and 40.4% Norphans and 45.5% controls having birth certificates (Table 10). It is no surprise that orphan children who may have moved homes (15.8%) or had a change of primary caregivers since the death of their mother, had the lowest rates of birth certificate availability. The rates of having immunization cards (referred to as Road To Health Cards) were higher than that of birth certificate eligibility in all three groups and orphans had the lowest rates of possession of cards (Table 11). Only 50% caregivers of

orphans compared with 66% norphans and 63.5% controls could produce their cards when asked. . Lack of immunization records and birth certificates in all three groups suggests the general low availability and importance attached to these documents. Unfortunately, these documents are absolutely necessary for accessing the welfare grants and could potentially pose as the biggest barriers to accessing welfare grants.

In terms of the material goods available to the children, there were no significant differences between the three populations except with respect to owning an extra set of clothes (Table 17b). Norphans had more access to extra set of clothes than either orphans or norphans and this difference was significant (Table 17c). This suggests that even within the same households, orphans and norphans do not have similar access to all resources. When asked what three resources would help the caregivers in looking after the children in the household better, most caregivers identified food, clothing and help with school expenses as most important. While the needs for food and clothing was significantly different between orphans and norphans groups, this difference was not significant between orphans and controls. Orphans were however, significantly different from norphans and orphans in their need for help with schoolwork. One reason could be the lower levels of literacy and older age of the caretakers of orphan children.

Only 15.8% of the orphaned children had moved since the death of their mother. Even though data on psychosocial impact of the mother's death was not conducted in this study, it clear from the literature that it is in the child's interest to remain in the familiar environments of their homes and community after the death of their parent(s)(Hunter, 2000; UNDP, 1998). While 84.2% of the orphans identified in this study did not move after the death of their mother, the household they are living in

may be experiencing increased financial stress due to the lack of productive family members from the household. However, an absence of a baseline data did not allow us to test this hypothesis. When asked if the household had to sell assets to cope with the loss of a family member, only 18.9% of the orphan caregivers said that they sold assets as financial coping strategies after the death of the child's mother. This could mean either that the mother of the child was not financially contributing to the household income monetarily or that the family did not have sellable assets or had other means of dealing with financial stresses, if any. In absence of in-depth questioning and lack of baseline data about the prior status of the economics of the household, no conclusions can be drawn about coping mechanisms or financial difficulties.

It is evident that the awareness of grants is very low (Table 23). None of the caregivers of the orphans were aware of Child Support grant, Care Dependency grant or the disability grant. While a low uptake of grants in these areas was expected, a complete lack of awareness of these grants was quite shocking. Even more surprisingly, the caregivers of orphan and norphan (often different caregivers within the same household) had different levels of awareness about these grants. About 17% of the norphan caregivers and 19% controls had heard of the grant but none of the caregivers of orphan children had heard of the Child Support Grants.

Another interesting finding in this study was that only 48.7% orphans compared to 80% norphan and 76.9% controls reported that the child's father was alive. We did not ask the reason for death of the mother, but it seems likely that many of the deaths were due to HIV/AIDS related, whereby once either parent is infected and they are still sexually involved, it could mean that both parents are eventually infected and die. It is

therefore, likely that many of the orphans in this study are AIDS orphans although this was not asked of the participants.

Statistical analysis was performed to determine the confidence with which we can conclude that differences in our results are due to actual differences in the population. It must be stressed that the small sample size and low power make insignificant differences inconclusive. This study was designed to understand the needs of the community and their awareness of the grants. Lack of additional questions makes it difficult to understand whether the orphan and norphan children are worse off than the controls.

Chapter 7

Limitations

During the research period, households identified as “Control” and “Orphan” household may have shifted from one group to another, i.e., an “orphan” household may have lost orphans or no longer be caring for the orphaned child and a “control” household may have taken in an orphan child. This could not be avoided and the extent to which this happened also provides valuable information. It is difficult to measure the impact of the epidemic on households because we do not have information on the status of the households before they took in orphans. More sophisticated research is necessary to evaluate the psychosocial support necessary for distressed orphaned children living in impoverished conditions and dealing with the death of their mother. Since the cases and controls were selected beforehand, each subject was assessed only once and their response reflects opinions only at one point in time. This cross-sectional nature of the design of this study would have been especially problematic had there been a governmental policy reform taking effect immediately or if the caregivers financial resources were going to change significantly over a period of time, but this was not likely to happen. Assuming that the financial resources of this predominantly poor community are stable, the cross sectional nature of the study is acceptable. Since the survey tool was a questionnaire administered by trained staff, self reporting about material resources available to the families may have been somewhat biased if the subjects were embarrassed about their poverty and wanted to make better impressions about their ability to look after the children in the house.

Chapter 8

Ethical consideration

This general population from which the sub-sample was derived has participated in several other studies conducted by local NGOs and academic institutions. This could have serious implications in terms of disgruntled communities distrusting the activities of the NGOS if these communities were not receiving any benefits from the interventions introduced. It is therefore, necessary to ensure that the community benefits from each of the study conducted by following up with effective and sustainable interventions, and evaluations of the effectiveness of the interventions, once they are in place.

Chapter 9

Recommendations

Recommendations based on the results of this study are as follows:

9.1 Increase the capacity of children and young people to meet their needs

It is important to recognize that children, adolescents and young adults are as much part of the solution as they are part of the crisis. Encouraging children to participate and supporting them in defining their needs and giving them an opportunity to take control of their lives would lead to a healthier society. Close to 53% of the orphan households expressed need for help with school- work. By encouraging older school children to tutor the younger ones after class would build strong relationship between the younger members the society. Encouraging peer education could potentially be a constructive ways of talking responsibility and control over their lives; this could engender greater willingness to avoid behavior that could lead to future HIV infections

9.2 Rethinking the school curricula to include more vocational training opportunities

While the importance of formal education is obvious, rethinking the school curricula to include more vocational training classes and workshops could potentially equip the children with better life skills for employment or for generating their own employment when they leave school. Scholarships could be introduced by way of arranging apprenticeships with local artisans or businesses.

9.3 Improving village water and sanitation

Seeing that both case and control households in this study reported that children, sometimes as young as 5 years old were involved in labor-intensive tasks of fetching water, improving the water and sanitation within the communities could reduce the labor required to meet basic needs.

9.4 Increasing awareness of Social Welfare provisions

Community workers need to be mobilized to spread the word and increase the awareness of government sponsored grants in the community. Radio announcements and poster campaigns need to be undertaken. In addition to increasing awareness, local NGO's could assist by facilitating paper-work formalities and helping eligible caregivers to fill out the application and access these grants.

9.5 Encouraging parents to write wills before their death

The study results indicate that only 6.7 % of the parents left assets behind for the families taking care of the children. The reason for such a low percentage was not investigated in the presented study, but it could be hypothesized that parents live in denial about their disease and often do not make arrangements for their children. Often inheritance laws are complex, especially when the right of a widowed woman and her children is concerned. Informing and encouraging community health workers to initiate conversations with parents urging them to write wills before their death may go a long way in making arrangements for the children's future.

9.6 Food subsidies and vouchers

Since food was identified as a need for most children, interventions need to be sustainable. Even though the school enrollment rates are high, having meals provided at

schools may select against children who are enrolled but remain absent or for non-enrolled younger children. Perhaps having food subsidies for households to enable enough food for all members of the family (young and old) would be more effective in improving the overall nutritional status of the community.

9.7 Clothing needs:

9.7.1. Clothing drives at community centers

Most households in the orphan and control households identified a need for clothes. Having clothing drives at the community centers could help communities share their resources better. Also abolishing school uniforms could help reduce the burden of additional special dress codes and the financial costs associated with it. This may also help alleviate costs associated with schooling needs, which were identified as another need.

9.7.2 Capacity building

Another intervention for local NGOs could be to provide fabric, have workshops with young adults, and invite older skilled women to teach and learn sewing from another. Such vocational skill to generate income and build local capacity

9.8 Increasing social pension and relaxing age criterion

Since the majority of the caregivers are older especially in the case of caregivers of orphaned children (mean age of 54 years), reducing the age for social pension eligibility and increasing the amount of money could be financially beneficial to older grandparents in the community.

Chapter 10

Recommendations for the government of South Africa

Having examined the dire situation of child poverty in South Africa and more specifically the needs of children and their caregivers in this study, it is evident that the commitments and obligations of the government of South Africa are not being upheld. This section presents the recommendations arising out of a national consultative workshop on social security provisions for children in South Africa. The workshop was co-convened by the Child Health Policy Institute at the University of Cape Town, The Soul City Institute for health and Development, Children's right center and the committee of inquiry into a comprehensive Social Security System and brought together grass-roots NGOs, Community Based Organizations (CBOs), research units, academics, provincial and national government departments, policy-makers, and parliamentarians.

10.1 Child Support Grant (CSG):

- Extend coverage of CSG to all children up to 18yrs of age
- Increase amount - determined by objective poverty measure & linked to inflation
- Abolish means-testing and provide universal access
- Improve accessibility to children without Primary Care Givers – develop and strengthen NGOs, CBOs, Community structures to assess and administer the grants.
- Administrative problems should be dealt as a priority to improve delivery mechanisms and grant processing capacity and increase access to the grants

10.2 Care-Dependency Grant (CDG):

- The purpose of the CDG should be to meet the extra needs of the child due to the health condition, to promote the child's survival, development, protection and participation.
- Eligibility should be based on need due to the health condition.
- Extend provisioning to children with moderate disabilities and chronic illnesses, including HIV/AIDS.Remove clause referring to permanent/ 24hr care. **10.3 Foster Care Grant (FCG):**
- Subsidize adoptions to encourage families to adopt children.
- Simplify process of accessing, especially for family members and do not mandate legal adoption
- Support for fostering AIDS orphans: free health and education, tax rebates for foster and biological children, coverage of the funeral costs.

These short-term recommendations are a synthesis of these stakeholders and are consistent with the findings of the needs of in this study.

Chapter 11

Recommendations for Future Study

In the absence of any prior data, this study provides valuable information about the needs of children and their caregivers in the area especially since this is the first time that such an assessment was undertaken in these regions. While the research topics were not exhaustive, the results of from this study can inform interventions designed to meet these needs. It will, however, be necessary to follow up this population with more studies to refine and inform further interventions. An evaluation of the interventions once initiated also needs to be planned to understand whether in fact the interventions are in fact reaching those who most need them. In the study presented here, care was taken only to ask those questions, which would inform intervention designs. The questionnaire was also kept short in the interest of time and to increase participation and so the scope of this assessment was limited.

For better interventions, further studies should seek to understand:

1) Heath status of the caregiver to determine if the extended family structure would be sustainable if the caregiver was sick and how this impacts the family
2) Health status of the child to identify special needs especially if the child was infected with HIV/AIDS.
3) How often children missed school and the main reason for absenteeism to help identify strategies to increase school attendance.
4) Whether emotional and psychosocial support is available to children who have to cope with the death of parent(s), sibling separation and migration away from their homes. For instance, one of the interviewers noted in extra notes in the

questionnaire that a 77-year-old grandmother reported that her grand-daughter (12 years old) has been depressed and withdrawn since the death of her mother. The grandmother also suspected that the child's uncle and other male acquaintances living in the household were sexually abusing the child. This study did not undertake a psychosocial analysis due to lack of time and resources, but such research would be very helpful in addressing such problems within the community

5) The stigma related to death of parents due to AIDS: This would be helpful in understanding the sort of emotional/ psychosocial trauma experienced by the children and the environment they live in within the household
6) The analysis from this study is meant to inform interventions in the field and basic statistics were conducted. It would be interesting, however, to analyze the results in more detail by building multiple logistic models to determine predictors of certain outcomes.

Chapter 12

Conclusion

Although the combination of poverty and the HIV/AIDS epidemic is putting traditional household units under dire stress, a majority of families are still providing some level of care for affected children but this is going to be dependent on the availability of resources. The results from this study do not conclusively prove whether the orphans and norphans are in greater need of resources than control but it is apparent that most households in this community are poor and need interventions which are sustainable, will help build the capacity of communities and help meet their needs. The current measures of social assistance available for children and orphans living in poor households are insufficient and the commitment of the government to protecting the rights of the children is not being upheld in practice.

The scope of the research and analysis in this study was limited but it reveals some needs of vulnerable children and their caregivers and makes recommendations for communities, civil society and the government. This assessment examines the material needs of the caregivers at one point in time, and the nature of the AIDS epidemic may place additional demands on the families in the future. Such assessments will need to be repeated and include other components like psychosocial support necessary for household members in addition to material needs. Periodic evaluations of interventions, once they are in place would be important to ensure that the needs are being met and reaching the most needy.

Appendix 1

Tables presenting the findings of the study

1. General characteristics of the household

Table 1: Average number of members in the household

Households	Number of members	Standard Deviation
Orphans	8.85	3.219
Norphans:	8.195	2.929
Controls:	9.443	3.195

Table 2: Average number of rooms in the household

Household	Number of rooms	Standard Deviation
Orphans	6.263	2.839
Norphans:	7.129	3.204
Controls:	6.189	4.6

2. Child Information

Table 3: Average age of the children in the households

Child	**Mean (years)**	**Standard Deviation**
Orphans	8.77	3.818
Norphans	6.0188	4.482
Controls	6.886	4.098

Table 4: Sex of the children sampled in the households

Child	**Male**	**Female**
Orphan	44%	56%
Norphan	49.06%	45.57%
Control	45.57%	54.43%

3. Caregiver Information:

Table 5: Sex of the caregivers of children in the households

	Male	**Female**
Orphan	19.7%	80.3%
Norphan	19.6%	90.4%
Control	17.9%	82.1%

Table 6: Mean age of the caregivers of children in the households

	Mean (years)	Standard Deviation	Range
Orphans	53.75	12.5445	(Range: 25-85)
Norphans	46.46	16.8835	(Range 19-77)
Controls	43.64	12.4472	(Range 19-73)

Table 7: Percentage of caregivers who were considered literate based on being able to read a script in Zulu

	Literacy rates
Orphans	51.3%
Norphans	71.2%
Controls	61.5%

Table 8: Employment status of caregivers (both in the formal or informal sectors)

	Employed	Unemployed
Orphan	62.8%	37.3%
Norphan;	67.9%	32.1%
Control	58.8%	41.3%

Table 9: Differences between orphans, norphans and controls with respect to caregivers literacy level, employment status and gender

Care giver information	Chi- Square	P-value	Significant/Non Significant
Literate	5.4922	0.0642	Not significant
Employment status	0.7981	0.6710	Not significant
Gender	2.6262	0.2690	Not significant

Table 10: Relationship of caregivers to orphaned children

Father	10.5%
Grandmother	65.8%
Older sister	3.9%
Older brother	1.3%
Maternal aunt	18.4%

Table 11: Relationship of caregivers to norphans and controls

	Norphans	Controls
Mother	46.2%	43.6%
Father	5.8%	20.5%
Grandmother	38.4%	28.5%
Older sister	0%	2.6%
Older brother	0%	0%
Maternal aunt	7.7%	5%

Table 12: Percentage of children with birth certificates

	ORPHANS	Norphans	Controls
Yes	30.3%	40.4%	45.5%
No	63.2%	59.6%	53.2%
Don't know	6.6%	0%	1.3%

Table 13: Percentage of children with Road to Health Card (Immunization cards)

	Orphans	Norphans	Controls
Yes	65.8%	88.5%	84.4%
No	27.6%	11.5%	14.3%
Card produced	50%	66%	63.8%

Table 14: Caregivers knowledge about whether the child is fully immunized for his or her age

	Yes	No	Don't Know
Orphans	63.2%	9.2%	27.6%
Norphans	82.7%	7.7%	9.6%
Controls	80.5%	10.4%	9.1%

Table 15: Differences between orphans, norphans and controls with respect to having Birth Certificate and Road to Health Card

Outcome	Chi- Square	P-value	Significantly different
Birth Certificate	8.7898	0.0666	Not significant
Self reported immunization status	**12.6082**	**0.0134**	**Significant**
Road to Health Card	**13.9989**	**0.0073**	**Significant**
Misplaced Road to Health Card	2.5394	0.2809	Not-significant
Could not find Road to Health Card	5.7031	0.0578	Not significant

Tables 16: Differences, with respect to caregiver's knowledge of child's immunization status and availability of Road to Health Card for:

16a Orphans vs. Norphans

Outcome	Chi- Square	P-value	Significantly different
Self reported Immunization status	6.9587	0.0308	**Significant**
Road to Health Card	9.6315	0.0081	**Significant**

16b. Orphans vs. Control

Outcome	Chi- Square	P-value	Significantly different
Child immunized for his/her age	8.8423	0.0120	**Significant**
Owning Road to Health Card	7.7420	0.0208	**Significant**

Table 16c. Norphan vs. Control

Outcome	Chi- Square	P-value	Significantly different
Child immunized for his/her age	0.3028	0.8595	Not significant
Owning Road to Health Card	0.9656	0.6171	Not significant

Table 17a: Physical material resources available to the child

	Orphans	Norphans	Controls
Blankets	61.8%	57.7%	48.1%
Mattress	17.1%	11.5%	13%
>1 set of clothes	84.2%	100%	79.2%
Shoes	56.6%	55.8%	70.1%

Table 17b: Differences between orphan, norphans and controls with respect to material resources available to the children

	Chi- Square	P-value	Significantly different
Blankets	0.9847	0.6112	Not significant
Mattress	3.1551	0.2065	Not significant
>1 set of clothes	**12.0359**	**0.0024**	**Significant**
Shoes	3.7394	0.1542	Not significant

Table 17 c: Difference between groups with respect to availability of extra set of clothes

	Chi- Square	**P-value**	**Significantly different**
Orphan vs Controls	06369	0.4248	Not significant
Orphans vs Norphans	**9.2267**	**.0024**	**Significant**
Norphans vs Controls	**12.5587**	**.004**	**Significant**

Table 18: Perceived needs of the caretaker for orphans, controls and norphans

	Orphans	**Norphans**	**Controls**
Food	82.1%	75%	59.1%
Clothes	87.2%	80.5%	86.4%
School Fees	69.2%	50%	56.8%
Help with school work	52.6%	17%	43%
Medical Care	29.5%	29%	25%
Shelter	3.8%	2.4%	2.3%

Table 19: Differences between orphans, norphans and controls with respect to perceived needs

Outcome	**Chi- Square**	**P-value**	**Significantly different**
Food	0.8930	0.6399	Not significant
Clothes	1.6438	0.4396	Not significant
Shelter	0.4532	0.7972	Not Significant
Beds and blankets	4.5586	0.1024	Not-significant
Help with School work	**16.9045**	**0.0002**	**Significant**
Medical Care	3.6612	0.1603	Not significant
General supervision of the child	1.6535	0.4375	Not significant

Table 20: Differences between orphans, norphans and controls with respect to the caregivers need for school fees, clothes, medical care and food

Outcome	**Chi- Square**	**P-value**	**Significantly different**
School fees	14.1862	0.0008	**Significant**
Clothes	6.5820	00372	**Significant**
Medical Care	1.9658	0.3742	Not Significant
Food	0.2372	0.8882	Not Significant

Tables21: Differences with respect to school fees and clothes for:

Table 21a: Orphan vs. Norphan

Outcome	Chi- Square	P-value	Significantly different
School fees	13.3801	0.0003	**Significant**
Clothes	6.6215	0.0101	**Significant**

Table 21b: Orphan vs Control

Outcome	Chi- Square	P-value	Significantly different
School fees	6.7673	0.0093	**Significant**
Clothes	2.0317	0.1541	Not Significant

Table 21c: Norphans vs. Control

Outcome	Chi- Square	P-value	Significantly different
School fees	**1.7817**	**0.1819**	**Not Significant**
Clothes	**1.6441**	**0.1998**	**Not Significant**

Table 22: Percentage of children receiving any Grants (including Social pension, CSG, FCG, CDG)

	Orphans	Norphans	Controls
Yes	5.1%	5.7%	13.8%
No	94.9%	94.3%	86.3%

Table 23: Caregiver's awareness of grants

	Orphans	Norphans	Controls
Child Support Grant (CSG)	0%	17%	18.8%
Care Dependency Grant (CDG)	0%	1.9%	5%
Disability Grant (DG)	0%	3.8%	3.8%
Foster Care Grant (FCG)	3.8%	1.9%	0%

Table 24: Difference between groups based on caregiver's awareness of grants

	Chi- Square	P-value	Significantly different
Child Support grant	**7.1366**	**0.0282**	**Significant**
Care dependency grant	4.3438	0.1140	Not significant
Foster Care Grant	3.2167	0.2002	Not significant
Disability Grant	2.9284	0.2313	Not significant

Table 25. Difference between the different groups with respect to awareness of Child support grant

Groups	Chi- Square	P-value	Significantly different
Orphan and Norphan	2.8585	0.0909	Not significant
Orphan and Control	6.0046	0.0143	**Significant**
Norphan and Control	0.8591	0.3540	Non significant

Table 26: Difference between orphans, norphans and controls with respect to awareness of child support grant, foster care grant and social pensions

Outcome	Chi- Square	P-value	Significantly different
Child support grant	6.0727	0.0480	Significant
Foster care grant	3.5338	0.1709	Not significant
Social Pension	3.3229	0.1899	

Care dependency grant and disability grants were not reported because none of the groups were receiving the grants and so there was no significant difference between the groups.

Table 27: Orphan residential status since death of mother

% Moved:	15.8%
% Did not moved:	84.2%

Table 28: Children whose fathers are alive

	Yes	No	Don't Know
Orphans	48.7%	26.3%	25%
Norphans	80.8%	17.3%	1.9%
Controls	76.9%	16.7%	6.4%

Table 29: Percentage of children whose fathers live in the same household as them

	Yes	No
Orphans	29.7%	70.3%
Norphans	32.7%	67.3%
Controls	48.7%	51.3%

Table30: Percentage of children whose fathers support them financially

	Yes	**No**
Orphans	14.5%	85.5%
Norphans	38.5%	61.5%
Controls	52.6%	47.4%

Table 31: Average number of meals eaten by child during the last 24 hours (Not very reliable, because the question was unclear about what constitutes "eating")

	Times the child are in 24 hrs	**Standard Deviation**
Orphans	3	0.9285
Norphans	3	1.2470
Controls	3	1.0112

Table 32: Assets left behind by parents of the orphaned child

Yes	6.7%
No	92.0%
Don't know	1.3%

(Furniture and cattle were common responses to nature of assets left behind)

Table 33: Whether the household had to sell any assets since the child had come to live in the household

Yes	18.9%	
No:	81.1%	
Don't know	36	

Tables 34:Relationship of child to financial provider for:

Table 34a: Child's education

Table 34a_1: Orphans

Nobody	3.3%
Current caregiver of child	16.4%
Father	16.4%
Other relatives living in the house	3.3%
Other (mostly grandmother or grandfather)	60.7%

Table 34a_2: Norphans and Controls

	Norphan	Control
Nobody	0%	21.3%
Father	42.4%	32.8%
Mother	15.2%	19.7%
Relatives	3.0%	0%
Family Friends	0%	1.6%
Other (mostly grandparents)	39.4%	24.6%

Tables 34b: Clothes

Table 34b_1: Orphans

Nobody	2.6%
Current caregiver of child	21.1%
Father	11.8%
Other relatives living in the house	1.3%
Household members	3.9%
Family friends	
Other (mostly grandmother or grandfather)	

Table 34b_2. Norphans and Controls

	NORPHAN	CONTROL
Nobody	0%	2.5%
Father	35.4%	38.0%
Mother	22.9%	25.3%
Relatives	2.1%	1.3%
Family Friends	0%	2.5%
Other (mostly grandparents)	39.6%	30.4%

Tables 34c Food

Table 34c_1: Orphans

Nobody	1.3%
Current caregiver of child (?)	22.4%
Father	10.5%
Other relatives living in the house	2.6%
Other (mostly grandmother or grandfather)	60.5

Table 34c_2: Norphans and Controls

	Norphans	**Control**
Nobody	0%	2.5%
Father	33.3%	35.4%
Mother	22.9%	24.1%
Relatives	2.1%	1.3%
Family Friends	0%	2.5%
Other (mostly grandparents)	41.7%	34.2%

Tables 34d: Medical Care

Table 34d_1: Orphans

Current caregiver of child	21.1%
Father	7.9%
Other relatives living in the house	3.9%
Family friends	1.3%
Government funding	1.3%
Other (mostly grandmother or grandfather or free clinic)	64.5

Table 34d_2: Norphans and Controls

	Norphan	**Control**
Father	31.3%	32.9%
Mother	20.8%	22.8%
Relatives	4.2%	1.3%
Family Friends	0%	2.5%
Other (mostly grandparents and free clinic)	43.8%	40.5%

Appendix 2

Tables for Chapter1

TableV: Categories of Provincial Expenditure as Percentage of the total Provincial Expenditure

	1999/00	2000/01	2001/02	2002/03
Education	39.85%	39.39%	39.43%	39.55%
Health	24.04%	24.00%	24.17%	24.09%
Welfare	18.91%	18.67%	18.44%	18.09%
Local Government Transfers	0.64%	0.56%	0.54%	0.52%
Contingency Reserve	0.00%	0.25%	0.30%	0.34%
Other	16.55%	17.14%	17.12%	17.40%
Total	100.00%	100%	100%	100.00%

Table V, shows that although the composition of provincial budgets is not projected to change significantly over the next three years, the share allocated to Welfare is projected to decline slightly from the current level of 19% to 18% by 2002/03.
(Source: Idasa Budget Services, 2000; A Review of the 2000/01 Provincial Welfare Budget)

Table VI: Provincial Welfare Budget

Nominal Figures					Nominal Change		Real Change	
R'000	1999/00	2000/01	2001/02	2002/03	Change over whole period	Change from last year	Change from Whole period	Change from last year
Eastern Cape	3680493	3950911	4140874	4228730	14.9%	7.3%	-1.4%	1.4%
Free State	1222181	1262256	1290690	1290814	5.6%	3.3%	-9.4%	2.4%
Gauteng	2368515	2630038	2770971	2938264	24.1%	11.0%	6.4%	4.9%
KwaZulu-Natal	3796905	4064420	4324945	4386458	15.5%	7.0%	-0.9%	1.2%
Mpumalanga	1062378	1212729	1273564	1343877	26.5%	14.2%	-8.5%	7.9%
Northern Cape	607077	634270	650077	661971	9.0%	4.5%	-6.4%	-1.3%
Northern Province	2132705	2550337	2548415	2684733	25.9%	19.6%	8.0%	13%
North West	1397506	1450097	1557000	1603000	14.7%	3.8%	-1.6%	1.9%
Western Cape	2213011	2266381	2296358	2388348	7.9%	2.4%	-7.4%	-3.2%
Total	18480771	20021439	20852894	21526195	16.5%	8.3%	-.01%	2.4%

Table VI shows that while Provincial Welfare expenditure is planned to grow by 2.4% in the new financial year

Table VII: Social Security as a percentage of Welfare budgets

	1999/00	**2000/01**	**2001/02**	**2002/03**
Eastern Cape	93.63	92.95	93.04	92.94
Free State	89.02	88.70	88.31	88.01
Gauteng	81.02	80.18	80.00	80.00
***KwaZulu-Natal**	94.08	93.19	92.23	91.49
Mpumalanga	91.92	92.14	91.27	90.84
Northern Cape	88.65	88.83	87.96	87.72
Northern Province	95.42	94.90	94.70	94.70
North West	92.58	92.76	na	na
Western Cape	83.37	82.92	82.82	83.17
Total	**90.44**	**89.42**	**82.71**	**82.51**

The Social Security programme is responsible for paying social grants to the aged, disabled and poor children. In real terms, Social Security expenditure is projected to decrease slightly over the MTEF period. However, as provincial Welfare budgets are planned to grow slightly over this period, the Social Security allocation will comprise a smaller share of the provincial Welfare budget than was the case in the past

Table VIII: Social Welfare and Social Assistance programs.

Nominal Figures					Nominal Change		Real Change	
R'000	1999/00	2000/01	2001/02	2002/03	Change over whole period	Change from last year	Change from Whole period	Change from last year
Eastern Cape	200223	230382	238332	246857	23.3%	15.1%	5.8%	8.7%
Free State	100348	105188	112451	114229	13.8%	4.8%	-2.3%	-0.9%
Gauteng	364352	417880	445295	472179	29.6%	14.7%	11.2%	8.4%
KwaZulu-Natal	198581	219136	268937	288937	45.5%	10.4%	24.8%	4.3%
Mpumalanga	67762	67553	76484	83464	23.2%	-0.3%	5.7%	-5.8%
Northern Cape	48659	52701	55782	57128	17.4%	8.3%	0.7%	2.3%
Northern Province	52743	75296	78214	82398	56.2%	42.8%	34.0%	34.9%
Western Cape	238846	227846	230319	232641	-2.6%	-4.6%	-16.4%	-9.9%
Total	1271514	1395982	1505814	1577833	24.1%	9.8%	6.5%	3.8%

Table VII: **Social Welfare and Assistance programs fund**

Appendix 3 Orphan and Control Questionnaires

Orphan (Case) Questionnaire

Hello my name is _____ and I am working with World Vision. We would like to ask you some questions about the children in the household especially in regard to their education and well-being.

Are there any children in the household under 15 years of age who have lost their biological mother?

If yes, continue
If No, stop interview and thank them for their time.

While you will not directly benefit monetarily from the study, your response is very important for our study and in advising the community leaders on ways to improve the health, education and general well being of the child and in protecting the rights of the child. We would greatly appreciate your help in responding to the survey. This will take approximately 30 minutes. All your responses will be confidential. Some of the questions may be personal in nature and you may choose not to answer them. You may stop me at any point in the interview if you do not wish to continue the interview.

Do you have any questions about the study or about your participation?
(ANSWER ANY QUESTIONS THAT THE PARTICIPANT MAY HAVE)

Do you agree to be interviewed today? Yes/No

If yes, proceed to Q. 1. If no, ask when you can come back and thank them for their time.

Date of Interview:_____

Interviewed by: _____ Initials:_____

Interview Results

1 = Completed
2 = Not at home
3 = Postponed
4 = Partially completed
5 = Refused participation
6 = Not eligible

If 2, 3 or 4 ask for permission to return and schedule a day and time

Return date D / M / Y Time _____

ORPHAN #1

Ward Number _____Ward Name_____

Household ID# _____ Head of household Name _____

Questions		Response	Skip
1. How many members currently live in the household?			
2. Age and sex of head of household		Age: Sex: 1 Male. 2 Female)	
3. Age and gender of all members living in the household Age	Sex (circle) Male Female		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
4. How many rooms are there in your house (kraal)?		Rooms:	
5a. Age and sex of child rounded to nearest year: (FOR THE SECOND CHILD, START AT 5b AT THE END OF THE SURVEY) (RANDOM SELECTION OF ORPHAN CHILDREN BY DRAWING NAMES FROM A HAT)		Age= Sex = 1 (Male) 2 (Female)	

6a. Who is the child's primary caregiver in this household? (Caregiver defined as person living in the household who spends the most time caring for the child and often makes decision about what the child eats) (IF MULTIPLE CAREGIVERS, INTERVIEW BASED ON WHOEVER IS AVAILABLE IF ALL ARE AVAILABLE, RANDOMLY SELECT BY DRAWING NAMES FROM A HAT)	Identify relationship: Father 1 Maternal grandmother 2 Paternal grandmother 3 Older sister 4 Older brother 5 Other_____ 6	
7a. Age of caregiver	Age:	
8a. Sex of caregiver	Male 1 Female 2	
9a. GIVE CARETAKER A PREPARED READING TEST (ONE SENTENCE OF A ZULU SCRIPT) WAS SHE ABLE TO READ THE SCRIPT?	Yes 1 No 2	
10a. Where did the child live before the death of the mother	Mother's house 1 Father's house 2 Grandparents 3 Same house as now 4 Neighbors house 5 Don't know 6 Refused 7	
11a. Since the death of the mother, has the child (say name) moved?	Yes 1 No 2 DNK 3 Refused 4	
12a. When did the mother of the child (say name) die How old was she when she died? _____	Date: D /M /Y Don't know…… 0	
13a. Is the biological father of the child alive?	Yes 1 No 2 DNK 3 Refused 4	14a 16a
14a. Does the father of the child live in this household?	Yes 1 No 2 DNK 3 Refused 4	
15a. Does the father support the child financially	Yes 1 No 2 DNK 3 Refused 4	
16a. Has the child ever been to school	Yes 1 No 2 DNK 3 Refused 4	17a 19a

17a. Is the child currently in school	Yes 1 No 2 DNK 3 3 Refused 4	
18a. How many years of school has the child completed?		
19a. If the child has ever been out of school, what were the main reasons for discontinuity of school?	0= Too young to go to school 1= Could not pay school fees 2= Needed to Work 3= needed to tend cattle 4= Family removed student 5= Expelled 6= Poor school performance/failed 7= No Place in school available 8= No Accessible school 9= Bad/poor quality of school 10= Sick 11 = Pregnant 12= Care for sick relative/parent 13= Political Concerns/ Violence 14= Boycott of school 15= Parents/family moved 16= Other (specify)	
20a. Does the child work in the house If yes, how many hours a day _____	Yes 1 No 2 DNK 3 Refused 4	
21a. Does the child work outside the house for money? If yes, describe the nature of work _____ How many hours _____	Yes 1 No 2 DNK 3 Refused 4	
22a. Does the child (say name) have a birth certificate (based on birth registration)	Yes 1 No 2 DNK 3 Refused 4	
23a. Does the child (say name) have a Road to health card If yes, ask to see the card Circle Card produced 1 Could not find it 2 Misplaced it 3	Yes 1 No 2 DNK 3 Refused 4	

24a. Is the child (say name) fully immunised for his/her age	Yes 1 No 2 DNK 3 Refused 4	
25a. How many times did the child eat in the last 24 hours	Did not eat 0 Once 1 Two times 2 Three times 3 Four times 4 Five times 5 More than 5 6	
26a. What did the child eat at these times (List below) 1. 2. 3. 4. 5		
27a. Does the child sleep on a mattress?	Yes 1 No 2 DNK 3 Refused 4	
28a. Does the child have a blanket?	Yes 1 No 2 DNK 3	
29a. Does the child own more than one set of clothes?	Yes 1 No 2 DNK 3 Refused 4	
30a. Does the child own a pair of shoes?	Yes 1 No 2 DNK 3 Refused 4	
31a. When the child's mother was ill or when she died, did you get any of the following support? (Circle all that apply)	None 0 Money 1 Food 2 Clothes 3 School fees for child 4 Emotional support 5 Other assistance, 6 (Explain)_____	33a

32a. Where did you get this support from?	Government Grants 1 Neighbours 2 Family members 3 Relatives living outside the house 4 Church 5 Social Welfare 6 Other, specify_____7	
33a. Are you receiving any of the following? Circle all that apply (Child support grant (R100, from July 2001 it is R110) (Care Dependency grant (R540, from July 2001 it is R570) (Foster child grant (R410) Child Disability grant (R540, from July 2001 it is 570)	None 0 Child Support grant 1 Care dependency grant 2 Foster child grant 3 Child disability grant 4 Social Pension 5 Welfare funds from non government sources 6 Other_____7 (specify)	37a
34a. Where did you first hear of the grants	Social Worker 1 Health care worker 2 Community worker 3 Health clinic 4 Neighbour 5 Friend 6 Relative 7 Newspaper 8 Television 9 Other_____ 10	
35a. How long did it take between applying for the grant and actually receiving it		
36a. What problems, if any did you have in receiving the grant(s): 1. 2. 3.		
37a. Do you know about following grants. Circle all that apply.	Yes / No 1=Child support grant(R100) 1 2 2=Care dependency grant (R540) 1 2 3=Foster care grant (R410) 1 2 4= Disability grant(R 540) 1 2	
38a. Do you (caregiver) work to earn money? If yes, how many hours each week do you work _____	No, unemployed 0 Yes, circle all that apply Handicrafts 1 Harvesting/field work 2 Shop keeper 3 Street vendor 4 Paid domestic work 5 Salaried work 6 Other_____7	

39a. (IF THE CHILD IS LESS THAN 10 YEARS) Who takes care of the child when you are busy or away at work	Nobody 0 Grandmother 1 Grandfather 2 Older brother 3 Older sister 4 Older cousins 5 Maternal aunt 6 Paternal aunt 7 Others _____8	
40a. Did the parents of the child leave behind any assets for you or for the child If Yes, describe the nature of the asset:	Yes 1 No 2 DNK 3 Refused 4	42a
41a. Who is taking care of the child's family assets? Explain relationship to child: _____		
42a. Who pays for the child's school fees and other related items	Nobody 0 Caregiver(You) 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
43a. Who pays for the child's clothing	Nobody 0 Caregiver(You) 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	

44a. Who pays for the child's food	Nobody 0 Caregiver(You) 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
45a. Who pays for medical care of the child	Nobody 0 Caregiver(You) 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
46a. What are the needs of the child that you are struggling to provide? (Circle all that apply)	School fees and other educational items 1 Food 2 Clothing 3 Transportation 4 Health care fees 5 Other, please specify 6	
47a. Please list the 3 most important things which will help your family in looking after the orphans? (DON"T READ LIST JUST USE CODE IF APPLICABLE) 1. 2. 3.	Food 1 Clothes 2 Shelter 3 Bed/Blankets 4 Help with school work 5 Transportation 6 Emotional support 7 Guidance 8 Medical problems 9 General supervision 10 Other_____ 11 (specify)	
48a. As a result of the death of the child's mother or as a result of adopting the child, have you had to sell any property/assets ?	Yes 1 No 2 DNK 3 Refused 4	

ORPHAN # 2

5b. Age and sex of child rounded to nearest year: (FOR THE SECOND CHILD, START AT 5b AT THE END OF THE SURVEY) (RANDOM SELECTION OF ORPHAN CHILDREN BY DRAWING NAMES FROM A HAT)	Age= Sex = 1 (Male) 2 (Female)	
6b. Who is the child's primary caregiver in this household? (Caregiver defined as person living in the household who spends the most time caring for the child and often makes decision about what the child eats) (IF MULTIPLE CAREGIVERS, INTERVIEW BASED ON WHOEVER IS AVAILABLE IF ALL ARE AVAILABLE, RANDOMLY SELECT BY DRAWING NAMES FROM A HAT)	Identify relationship: Father 1 Maternal grandmother 2 Paternal grandmother 3 Older sister 4 Older brother 5 Other_____ 6	
7b. Age of caregiver	Age:	
8b. Sex of caregiver	Male 1 Female 2	
9b. GIVE CARETAKER A PREPARED READING TEST (ONE SENTENCE OF A ZULU SCRIPT. WAS SHE ABLE TO READ THE SCRIPT?	Yes 1 No 2	
10b. Where did the child live before the death of the mother	Mother's house 1 Father's house 2 Grandparents 3 Same house as now 4 Neighbors house 5 Don't know 6 Refused 7	
11b. Since the death of the mother, has the child (say name) moved?	Yes 1 No 2 DNK 3 Refused 4	
12b. When did the mother of the child (say name) die How old was she when she died? _____	Date: D /M /Y Don't know…… 0	
13b. Is the biological father of the child alive?	Yes 1 No 2 DNK 3 Refused 4	14b 16b
14b. Does the father of the child live in this household?	Yes 1 No 2 DNK 3 Refused 4	

15b. Does the father support the child financially	Yes 1 No 2 DNK 3 Refused 4	
16b. Has the child ever been to school	Yes 0 No 1 DNK 3 Refused 4	17b 19b
17b. Is the child currently in school	Yes 1 No 2 DNK 3 Refused 4	
18b. How many years of school has the child completed?		
19b. If the child has ever been out of school, what were the main reasons for discontinuity of school?	0= Too young to go to school 1= Could not pay school fees 2= Needed to Work 3= needed to tend cattle 4= Family removed student 5= Expelled 6= Poor school performance/failed 7= No Place in school available 8= No Accessible school 9= Bad/poor quality of school 10= Sick 11 = Pregnant 12= Care for sick relative/parent 13= Political Concerns/ Violence 14= Boycott of school 15= Parents/family moved 16= Other (specify)	
20b. Does the child work in the house If yes, how many hours a day _____	Yes 1 No 2 DNK 3 Refused 4	
21b. Does the child work outside the house for money? If yes, describe the nature of work _____ How many hours _____	Yes 1 No 2 DNK 3 Refused 4	

22b. Does the child (say name) have a birth certificate (based on birth registration)	Yes 1 No 2 DNK 3 Refused 4	
23b. Does the child (say name) have a Road to health card If yes, ask to see the card Circle Card produced 1 Could not find it 2 Misplaced it 3	Yes 1 No 2 DNK 3 3 Refused 4	
24b. Is the child (say name) fully immunised for his/her age	Yes 1 No 2 DNK 3 3 Refused 4	
25b. How many times did the child eat in the last 24 hours	Did not eat 0 Once 1 Two times 2 Three times 3 Four times 4 Five times 5 More than 5 6	
26b. What did the child eat at these times (List below) 1. 2. 3. 4. 5		
27b. Does the child sleep on a mattress?	Yes 1 No 2 DNK 3 Refused 4	
28b. Does the child have a blanket?	Yes 1 No 2 DNK 3 Refused 4	
29b. Does the child own more than one set of clothes?	Yes 1 No 2 DNK 3 Refused 4	
30b. Does the child own a pair of shoes?	Yes 1 No 2 DNK 3 Refused 4	

31b. When the child's mother was ill or when she died, did you get any of the following support? (Circle all that apply)	None 0 Money 1 Food 2 Clothes 3 School fees for child 4 Emotional support 5 Other assistance, 6 (Explain)_____		33b
32b. Where did you get this support from?	Government Grants 1 Neighbours 2 Family members 3 Relatives living outside the house 4 Church 5 Social Welfare 6 Other, specify_____7		
33b. Are you receiving any of the following? Circle all that apply (Child support grant (R100, from July 2001 it is R110) (Care Dependency grant (R540, from July 2001 it is R570) (Foster child grant (R410) Child Disability grant (R540, from July 2001 it is 570)	None 0 Child Support grant 1 Care dependency grant 2 Foster child grant 3 Child disability grant 4 Social Pension 5 Welfare funds from non government sources 6 Other_____7 (specify)		37b
34b. Where did you first hear of the grants	Social Worker 1 Health care worker 2 Community worker 3 Health clinic 4 Neighbour 5 Friend 6 Relative 7 Newspaper 8 Television 9 Other_____ 10		
35b. How long did it take between applying for the grant and actually receiving it			
36b. What problems, if any did you have in receiving the grant(s): 1. 2. 3.			
37b. Do you know about following grants. Circle all that apply. 1=Child support grant(R100) 2=Care dependency grant (R540) 3=Foster care grant (R410) 4= Disability grant(R 540)	Yes 1 1 1 1	No 2 2 2 2	

38b. Do you (caregiver) work to earn money? If yes, how many hours each week do you work _____	No, unemployed 0 Yes, circle all that apply Handicrafts 1 Harvesting/field work 2 Shop keeper 3 Street vendor 4 Paid domestic work 5 Salaried work 6 Other_____7	
39b. (IF THE CHILD IS LESS THAN 10 YEARS) Who takes care of the child when you are busy or away at work	Nobody 0 Grandmother 1 Grandfather 2 Older brother 3 Older sister 4 Older cousins 5 Maternal aunt 6 Paternal aunt 7 Others _____8	
40b. Did the parents of the child leave behind any assets for you or for the child If Yes, describe the nature of the asset:	Yes 1 No 2 DNK 3 Refused 4	42b
41b. Who is taking care of the child's family assets? Explain relationship to child: _____		
42b. Who pays for the child's school fees and other related items	Nobody 0 Caregiver(You) 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	

43b. Who pays for the child's clothing	Nobody 0 Caregiver(You) 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
44b. Who pays for the child's food	Nobody 0 Caregiver(You) 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
45b. Who pays for medical care of the child	Nobody 0 Caregiver(You) 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
46b. What are the needs of the child that you are struggling to provide? (Circle all that apply)	School fees and other educational items 1 Food 2 Clothing 3 Transportation 4 Health care fees 5 Other, please specify 6	

47b. Please list the 3 most important things which will help your family in looking after the orphans? (DON"T READ LIST JUST USE CODE IF APPLICABLE) 1. 2. 3.	Food 1 Clothes 2 Shelter 3 Bed/Blankets 4 Help with school work 5 Transportation 6 Emotional support 7 Guidance 8 Medical problems 9 General supervision 10 Other_____ 11 (specify)	
48b. As a result of the death of the child's mother or as a result of adopting the child, have you had to sell any property/assets ?	Yes 1 No 2 DNK 3 Refused 4	

NORPHAN #1 (Non- orphan in orphan household)

5c. Age and sex of child (Say name) rounded to nearest year: (RANDOM SELECTION OF ORPHAN CHILDREN BY DRAWING NAMES FROM A HAT)	Age= Sex = 1 (Male) 2 (Female)	
6c. Who is the child's primary caregiver in this household ? (Caregiver defined as person living in the household who spends the most time caring for the child and often makes decision about what the child eats) (IF MULTIPLE CAREGIVERS, INTERVIEW BASED ON WHOEVER IS AVAILABLE IF ALL ARE AVAILABLE, RANDOMLY SELECT BY DRAWING NAMES FROM A HAT	Identify relationship: Mother 0 Father 1 Maternal grandmother 2 Paternal grandmother 3 Older sister 4 Older brother 5 Other_____ 6	
7c. Age of caregiver	Age:	
8c. Sex of caregiver	Male 1 Female 2	
9c. GIVE CARETAKER A PREPARED READING TEST (ONE SENTENCE OF A ZULU SCRIPT. WAS SHE ABLE TO READ THE SCRIPT?	Yes 1 No 2	
10c. Whose house is the child living in now?	Mother's house 1 Father's house 2 Grandparents 3 Same house as now 4 Neighbors house 5 Don't know 6 Refused 7	
11c. Is the biological father of the child alive?	Yes 1 No 2 DNK 3 Refused 4	12a 13a
12c. Does the father of the child live in this household?	Yes 1 No 2 DNK 3 Refused 4	
13c. Does the mother support the child financially	Yes 1 No 2 DNK 3 Refused 4	
14c. Does the father support the child financially	Yes 1 No 2 DNK 3 Refused 4	

15c. Has the child ever been to school	Yes 1 No 2 DNKY 3 Refused 4	16a
16c. Is the child currently in school	Yes 1 No 2 DNK 3 Refused 4	
17c. How many years of school has the child completed?		
18c. If the child has ever been out of school, what were the main reasons for discontinuity of school?	0= Too young to go to school 1= Could not pay school fees 2= Needed to Work 3= needed to tend cattle 4= Family removed student 5= Expelled 6= Poor school performance/failed 7= No Place in school available 8= No Accessible school 9= Bad/poor quality of school 10= Sick 11 = Pregnant 12= Care for sick relative/parent 13= Political Concerns/ Violence 14= Boycott of school 15= Parents/family moved 16= Other (specify)	
19c. Does the child work in the house If yes, how many hours a day _____	Yes 1 No 2 DNK 3 Refused 4	
20c. Does the child work for money? If yes, describe the nature of work _____ How many hours _____	Yes 1 No 2 DNK 3 Refused 4	
21c. Does the child (say name) have a birth certificate (based on birth registration)	Yes 1 No 2 DNK 3 Refused 4	

22c. Does the child (say name) have a Road to health card If yes, ask to see the card Circle Card produced 1 Could not find it 2 Misplaced it 3	Yes 1 No 2 DNK 3 Refused 4	
23c. Is the child (say name) fully immunised for his/her age	Yes 1 No 2 DNK 3 Refused 4	
24c. How many times did the child (say name) eat in the last 24 hours	Did not eat 0 Once 1 Two times 2 Three times 3 Four times 4 Five times 5 More than 5 6	
25c. What did the child eat at these times (List below) 1. 2. 3. 4. 5		
26c. Does the child (say name) sleep on a mattress?	Yes 1 No 2 DNK 3 Refused 4	
27c. Does the child (say name) have a blanket?	Yes 1 No 2 DNK 3 Refused 4	
28c. Does the child own more than one set of clothes?	Yes 1 No 2 DNK 3 Refused 4	
29c. Does the child own a pair of shoes?	Yes 1 No 2 DNK 3 Refused 4	
30c. Are you receiving any of the following? Circle all that apply (Child support grant (R100, from July 2001 it is R110) (Care Dependency grant (R540, from July 2001 it is R570) (Foster child grant (R410) Child Disability grant (R540, from July 2001 it is 570)	None 0 Child Support grant 1 Care dependency grant 2 Foster child grant 3 Child disability grant 4 Welfare funds from non government sources 5 Social Pension Other_____ (specify)	34e

31c. Where did you first hear of the grants	Social Worker 1 Health care worker 2 Community worker 3 Health clinic 4 Neighbour 5 Friend 6 Relative 7 Newspaper 8 Television 9 Other_____ 10	
32c. How long did it take between applying for the grant and actually receiving it		
33c What problems, if any did you have in receiving the grant(s): 1. 2. 3.		
34c. Do you know about following grants. Circle all that apply.	Yes No 1=Child support grant(R100) 1 2 2=Care dependency grant (R540) 1 2 3=Foster care grant (R410) 1 2 4= Disability grant(R 540) 1 2	
35c. Do you (caregiver) work outside of the home to earn money? If yes, how many hours each week do you work _____	No, unemployed 0 Yes, circle all that apply Handicrafts 1 Harvesting/field work 2 Selling food 3 Shop keeper 4 Street vendor 5 Paid domestic work 6 Salaried work 7 Other_____8	
36c. **(IF THE CHILD IS LESS THAN 10 YEARS OLD)** Who takes care of the child when you are busy or away at work	Nobody 0 Grandmother 1 Grandfather 2 Older brother 3 Older sister 4 Older cousins 5 Maternal aunt 6 Paternal aunt 7 Others _____8	

37c. Who pays for the child's school fees and other related items	Nobody 0 Mother 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
38c. Who pays for the child's clothing	Nobody 0 Mother 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
39c. Who pays for the child's food	Nobody 0 Mother 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	

40c. Who pays for medical care of the child	Nobody 0 Mother 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, Specify_____11	
41c. What are the needs of the child that you are struggling to provide? (Circle all that apply)	School fees and other educational items 1 Food 2 Clothing 3 Transportation 4 Health care fees 5 Other, please specify 6	
42c. Please list the 3 most important things which will help your family in looking after the orphans? (DON"T READ LIST JUST USE CODE IF APPLICABLE) 1. 2. 3.	Food 1 Clothes 2 Shelter 3 Bed/Blankets 4 Help with school work 5 Transportation 6 Emotional support 7 Guidance 8 Medical problems 9 General supervision 10 Other_____ 11 (specify)	

NORPHAN # 2 (Non Orphan in orphan household)

5d. Age and sex of child (Say name) rounded to nearest year: (RANDOM SELECTION OF ORPHAN CHILDREN BY DRAWING NAMES FROM A HAT)	Age= Sex = 1 (Male) 2 (Female)	
6d. Who is the child's primary caregiver in this household ? (Caregiver defined as person living in the household who spends the most time caring for the child and often makes decision about what the child eats) (IF MULTIPLE CAREGIVERS, INTERVIEW BASED ON WHOEVER IS AVAILABLE IF ALL ARE AVAILABLE, RANDOMLY SELECT BY DRAWING NAMES FROM A HAT	00Identify relationship: Mother 0 Father 1 Maternal grandmother 2 Paternal grandmother 3 Older sister 4 Older brother 5 Other_____ 6	
7d. Age of caregiver	Age:	
8d. Sex of caregiver	Male 1 Female 2	
9d. GIVE CARETAKER A PREPARED READING TEST (ONE SENTENCE OF A ZULU SCRIPT. WAS SHE ABLE TO READ THE SCRIPT?	Yes 1 No 2	
10d. Whose house is the child living in now?	Mother's house 1 Father's house 2 Grandparents 3 Same house as now 4 Neighbors house 5 Don't know 6 Refused 7	
11d. Is the biological father of the child alive?	Yes 1 No 2 DNK 3 Refused 4	12d 13d
12d. Does the father of the child live in this household?	Yes 1 No 2 DNK 3 Refused 4	
13d. Does the mother support the child financially	Yes 1 No 2 DNK 3 Refused 4	
14d. Does the father support the child financially	Yes 1 No 2 DNK 3 Refused 4	

15d. Has the child ever been to school	Yes 1 No 2 DNK 3 Refused 4	16d
16d. Is the child currently in school	Yes 1 No 2 DNK 3 3 Refused 4	
17d. How many years of school has the child completed?		
18d. If the child has ever been out of school, what were the main reasons for discontinuity of school?	0= Too young to go to school 1= Could not pay school fees 2= Needed to Work 3= needed to tend cattle 4= Family removed student 5= Expelled 6= Poor school performance/failed 7= No Place in school available 8= No Accessible school 9= Bad/poor quality of school 10= Sick 11 = Pregnant 12= Care for sick relative/parent 13= Political Concerns/ Violence 14= Boycott of school 15= Parents/family moved 16= Other (specify)	
19d. Does the child work in the house If yes, how many hours a day _____	Yes 1 No 2 DNK 3 3 Refused 4	
20d. Does the child work for money? If yes, describe the nature of work _____ How many hours _____	Yes 1 No 2 DNK 3 3 Refused 4	
21d. Does the child (say name) have a birth certificate (based on birth registration)	Yes 1 No 2 DNK 3 3 Refused 4	

22d. Does the child (say name) have a Road to health card If yes, ask to see the card Circle Card produced 1 Could not find it 2 Misplaced it 3	Yes 1 No 2 DNK 3 Refused 4	
23d. Is the child (say name) fully immunised for his/her age	Yes 1 No 2 DNK 3 Refused 4	
24d. How many times did the child (say name) eat in the last 24 hours	Did not eat 0 Once 1 Two times 2 Three times 3 Four times 4 Five times 5 More than 5 6	
25d. What did the child eat at these times (List below) 1. 2. 3. 4. 5		
26d. Does the child (say name) sleep on a mattress?	Yes 1 No 2 DNK 3 Refused 4	
27d. Does the child (say name) have a blanket?	Yes 1 No 2 DNK 3 Refused 4	
28d. Does the child own more than one set of clothes?	Yes 1 No 2 DNK 3 Refused 4	
29d. Does the child own a pair of shoes?	Yes 1 No 2 DNK 3 Refused 4	

30d. Are you receiving any of the following? Circle all that apply (Child support grant (R100, from July 2001 it is R110) (Care Dependency grant (R540, from July 2001 it is R570) (Foster child grant (R410) Child Disability grant (R540, from July 2001 it is 570)	None 0 Child Support grant 1 Care dependency grant 2 Foster child grant 3 Child disability grant 4 Welfare funds from non government sources 5 Social Pension Other_____ (specify)	34e
31d. Where did you first hear of the grants	Social Worker 1 Health care worker 2 Community worker 3 Health clinic 4 Neighbour 5 Friend 6 Relative 7 Newspaper 8 Television 9 Other_____ 10	
32d. How long did it take between applying for the grant and actually receiving it		
33d What problems, if any did you have in receiving the grant(s): 1. 2. 3.		
34d. Do you know about following grants. Circle all that apply. 1=Child support grant(R100) 2=Care dependency grant (R540) 3=Foster care grant (R410) 4= Disability grant(R 540)	Yes No 1 2 1 2 1 2 1 2	
35d. Do you (caregiver) work outside of the home to earn money? If yes, how many hours each week do you work _____	No, unemployed 0 Yes, circle all that apply Handicrafts 1 Harvesting/field work 2 Selling food 3 Shop keeper 4 Street vendor 5 Paid domestic work 6 Salaried work 7 Other_____8	

36d. **(IF THE CHILD IS LESS THAN 10 YEARS OLD)** Who takes care of the child when you are busy or away at work	Nobody 0 Grandmother 1 Grandfather 2 Older brother 3 Older sister 4 Older cousins 5 Maternal aunt 6 Paternal aunt 7 Others _____8	
37d. Who pays for the child's school fees and other related items	Nobody 0 Mother 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
38d. Who pays for the child's clothing	Nobody 0 Mother 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
39d. Who pays for the child's food	Nobody 0 Mother 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	

40d. Who pays for medical care of the child	Nobody 0 Mother 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, Specify_____11	
41d. What are the needs of the child that you are struggling to provide? (Circle all that apply)	School fees and other educational items 1 Food 2 Clothing 3 Transportation 4 Health care fees 5 Other, please specify 6	
42d. Please list the 3 most important things which will help your family in looking after the orphans? (DON"T READ LIST JUST USE CODE IF APPLICABLE) 1. 2. 3.	Food 1 Clothes 2 Shelter 3 Bed/Blankets 4 Help with school work 5 Transportation 6 Emotional support 7 Guidance 8 Medical problems 9 General supervision 10 Other_____ 11 (specify)	

Guidelines

DNK: Don't know
Sentences/words in caps or bold faced are for the interviewers only and not meant to be read to the participants.

Control Questionnaire

Hello my name is _____ and I am working with World Vision. We would like to ask you some questions about the children in the household especially in regard to their education and well being.

Are there any children in the household under 15 years of age who have lost their biological mother?

If yes, stop interview and thank them for their time.
If No, continue.

While you will not directly benefit monetarily from the study, your response is very important for our study and in advising the community leaders on ways to improve the health, education and general well being of the children and in protecting their basic rights as a child. We would greatly appreciate your help in responding to the survey. This will take approximately 30 minutes. All your responses will be confidential. Some of the questions may be personal in nature and you may choose not to answer them. You may stop me at any point in the interview if you do not wish to continue the interview.

Do you have any questions about the study or about your participation.

Do you agree to be interviewed today? Yes/No

If yes, proceed to Q. 1. If no, ask when you can come back and thank them for their time.

Date of Interview:_____

Interviewed by: _____ Initials:_____

Interview Results

1 = Completed
2 = Not at home
3 = Postponed
4 = Partially completed
5 = Refused participation
6 = Not eligible

If 2, 3 or 4 ask for permission to return and schedule a day and time

Return date D / M / Y Time _____

CONTROL #1

Ward Number _____ Ward Name _____

Household ID# _____ Head of household Name _____

Questions		Response	Skip
1e. How many members currently live in the household?			
2e. Age and sex of head of household		Age: Sex: 1 Male 2 Female)	
3e. Age and gender of all members living in the household Age	Sex (circle) Male Female		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
4e. How many rooms are there in your house (kraal)?		Rooms:	
5e. Age and sex of child (Say name) rounded to nearest year: (RANDOM SELECTION OF ORPHAN CHILDREN BY DRAWING NAMES FROM A HAT)		Age= Sex = 1 (Male) 2 (Female)	

6e. Who is the child's primary caregiver in this household ? (Caregiver defined as person living in the household who spends the most time caring for the child and often makes decision about what the child eats) (IF MULTIPLE CAREGIVERS, INTERVIEW BASED ON WHOEVER IS AVAILABLE IF ALL ARE AVAILABLE, RANDOMLY SELECT BY DRAWING NAMES FROM A HAT	00Identify relationship: Mother 0 Father 1 Maternal grandmother 2 Paternal grandmother 3 Older sister 4 Older brother 5 Other_____ 6	
7e. Age of caregiver	Age:	
8e. Sex of caregiver	Male 1 Female 2	
9e. GIVE CARETAKER A PREPARED READING TEST (ONE SENTENCE OF A ZULU SCRIPT. WAS SHE ABLE TO READ THE SCRIPT?	Yes 1 No 2	
10e. Whose house is the child living in now?	Mother's house 1 Father's house 2 Grandparents 3 Same house as now 4 Neighbors house 5 Don't know 6 Refused 7	
11e. Is the biological father of the child alive?	Yes 1 No 2 DNK 3 Refused 4	12a 13a
12e. Does the father of the child live in this household?	Yes 1 No 2 DNK 3 Refused 4	
13. 11e. Does the mother support the child financially	Yes 1 No 2 DNK 3 Refused 4	
14e. Does the father support the child financially	Yes 1 No 2 DNK 3 Refused 4	
15e. Has the child ever been to school	Yes 1 No 2 DNK 3 Refused 4	16a
16e. Is the child currently in school	Yes 1 No 2 DNK 3 Refused 4	

17e. How many years of school has the child completed?		
18e. If the child has ever been out of school, what were the main reasons for discontinuity of school?	0= Too young to go to school 1= Could not pay school fees 2= Needed to Work 3= needed to tend cattle 4= Family removed student 5= Expelled 6= Poor school performance/failed 7= No Place in school available 8= No Accessible school 9= Bad/poor quality of school 10= Sick 11 = Pregnant 12= Care for sick relative/parent 13= Political Concerns/ Violence 14= Boycott of school 15= Parents/family moved 16= Other (specify)	
19e. Does the child work in the house If yes, how many hours a day _____	Yes 1 No 2 DNK 3 Refused 4	
20e. Does the child work for money? If yes, describe the nature of work _____ How many hours _____	Yes 1 No 2 DNK 3 Refused 4	
21e. Does the child (say name) have a birth certificate (based on birth registration)	Yes 1 No 2 DNK 3 Refused 4	
22e. Does the child (say name) have a Road to health card If yes, ask to see the card Circle Card produced 1 Could not find it 2 Misplaced it 3	Yes 1 No 2 DNK 3 Refused 4	

23e. Is the child (say name) fully immunised for his/her age	Yes 1 No 2 DNK 3 Refused 4	
24e. How many times did the child (say name) eat in the last 24 hours	Did not eat 0 Once 1 Two times 2 Three times 3 Four times 4 Five times 5 More than 5 6	
25e. What did the child eat at these times (List below) 1. 2. 3. 4. 5		
26e. Does the child (say name) sleep on a mattress?	Yes 1 No 2 DNK 3 Refused 4	
27e. Does the child (say name) have a blanket?	Yes 1 No 2 DNK 3 Refused 4	
28e. Does the child own more than one set of clothes?	Yes 1 No 2 DNK 3 Refused 4	
29e. Does the child own a pair of shoes?	Yes 1 No 2 DNK 3 Refused 4	
30e. Are you receiving any of the following? Circle all that apply (Child support grant (R100, from July 2001 it is R110) (Care Dependency grant (R540, from July 2001 it is R570) (Foster child grant (R410) Child Disability grant (R540, from July 2001 it is 570)	None 0 Child Support grant 1 Care dependency grant 2 Foster child grant 3 Child disability grant 4 Welfare funds from non government sources 5 Social Pension Other_____ (specify)	40a

31e. Where did you first hear of the grants	Social Worker 1 Health care worker 2 Community worker 3 Health clinic 4 Neighbour 5 Friend 6 Relative 7 Newspaper 8 Television 9 Other_____ 10	
32e. How long did it take between applying for the grant and actually receiving it		
33e What problems, if any did you have in receiving the grant(s): 1. 2. 3.		
34e. Do you know about following grants. Circle all that apply. 1=Child support grant(R100) 2=Care dependency grant (R540) 3=Foster care grant (R410) 4= Disability grant(R 540)	 Yes 1 1 1 1	 No 2 2 2 2
35e. Do you (caregiver) work outside of the home to earn money? If yes, how many hours each week do you work _____	No, unemployed 0 Yes, circle all that apply Handicrafts 1 Harvesting/field work 2 Selling food 3 Shop keeper 4 Street vendor 5 Paid domestic work 6 Salaried work 7 Other_____8	
36e. **(IF THE CHILD IS LESS THAN 10 YEARS OLD)** Who takes care of the child when you are busy or away at work	Nobody 0 Grandmother 1 Grandfather 2 Older brother 3 Older sister 4 Older cousins 5 Maternal aunt 6 Paternal aunt 7 Others _____8	

37e. Who pays for the child's school fees and other related items	Nobody 0 Mother 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
38e. Who pays for the child's clothing	Nobody 0 Mother 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
39e. Who pays for the child's food	Nobody 0 Mother 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
40e. Who pays for medical care of the child	Nobody 0 Mother 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, Specify_____11	

41e. What are the needs of the child that you are struggling to provide? (Circle all that apply)	School fees and other educational items 1 Food 2 Clothing 3 Transportation 4 Health care fees 5 Other, please specify 6	
42e. Please list the 3 most important things which will help your family in looking after the orphans? (DON"T READ LIST JUST USE CODE IF APPLICABLE) 1. 2. 3.	Food 1 Clothes 2 Shelter 3 Bed/Blankets 4 Help with school work 5 Transportation 6 Emotional support 7 Guidance 8 Medical problems 9 General supervision 10 Other_____ 11 (specify)	

CONTROL # 2

5f. Age and sex of child (Say name) rounded to nearest year: (RANDOM SELECTION OF ORPHAN CHILDREN BY DRAWING NAMES FROM A HAT)	Age= Sex = 1 (Male) 2 (Female)	
6f. Who is the child's primary caregiver in this household ? (Caregiver defined as person living in the household who spends the most time caring for the child and often makes decision about what the child eats) (IF MULTIPLE CAREGIVERS, INTERVIEW BASED ON WHOEVER IS AVAILABLE IF ALL ARE AVAILABLE, RANDOMLY SELECT BY DRAWING NAMES FROM A HAT)	Identify relationship: Father 1 Maternal grandmother 2 Paternal grandmother 3 Older sister 4 Older brother 5 Other_____ 6	
7f. Age of caregiver	Age:	
8f. Sex of caregiver	Male 1 Female 2	
9f. GIVE CARETAKER A PREPARED READING TEST (ONE SENTENCE OF A ZULU SCRIPT. WAS SHE ABLE TO READ THE SCRIPT?	Yes 1 No 2	
10f. Whose house is the child living in now?	Mother's house 1 Father's house 2 Grandparents 3 Same house as now 4 Neighbors house 5 Don't know 6 Refused 7	
11f. Does the mother support the child financially	Yes 1 No 2 DNK 3 Refused 4	
12f. Is the biological father of the child alive?	Yes 1 No 2 DNK 3 Refused 4	14a 16a
13f. Does the father of the child live in this household?	Yes 1 No 2 DNK 3 Refused 4	
14f. Does the father support the child financially	Yes 1 No 2 DNK 3 Refused 4	
15f. Has the child ever been to school	No 1 Yes 2 DNK 3 Refused 4	21

16f. Is the child currently in school	Yes 1 No 2 DNK 3 Refused 4	
17f. How many years of school has the child completed?		
18f. If the child has ever been out of school, what were the main reasons for discontinuity of school?	0= Too young to go to school 1= Could not pay school fees 2= Needed to Work 3= needed to tend cattle 4= Family removed student 5= Expelled 6= Poor school performance/failed 7= No Place in school available 8= No Accessible school 9= Bad/poor quality of school 10= Sick 11 = Pregnant 12= Care for sick relative/parent 13= Political Concerns/ Violence 14= Boycott of school 15= Parents/family moved 16= Other (specify)	
19f. Does the child work in the house If yes, how many hours a day _____	Yes 1 No 2 DNK 3 Refused 4	
20f. Does the child work for money? If yes, describe the nature of work _____ How many hours _____	Yes 1 No 2 DNK 3 Refused 4	
21f. Does the child (say name) have a birth certificate (based on birth registration)	Yes 1 No 2 DNK 3 Refused 4	
22f. Does the child (say name) have a Road to health card If yes, ask to see the card Circle Card produced 1 Could not find it 2 Misplaced it 3	Yes 1 No 2 DNK 3 Refused 4	

23f. Is the child (say name) fully immunised for his/her age	Yes 1 No 2 DNK 3 Refused 4	
24f How many times did the child (say name) eat in the last 24 hours	Did not eat 0 Once 1 Two times 2 Three times 3 Four times 4 Five times 5 More than 5 6	
25f. What did the child eat at these times (List below) 1. 2. 3. 4. 5		
26f. Does the child (say name) sleep on a mattress?	Yes 1 No 2 DNK 3 Refused 4	
27f. Does the child (say name) have a blanket?	Yes 1 No 2 DNK 3 Refused 4	
28f. Does the child own more than one set of clothes?	Yes 1 No 2 DNK 3 Refused 4	
29f. Does the child own a pair of shoes?	Yes 1 No 2 DNK 3 Refused 4	
30f Are you receiving any of the following? Circle all that apply (Child support grant (R100, from July 2001 it is R110) (Care Dependency grant (R540, from July 2001 it is R570) (Foster child grant (R410) Child Disability grant (R540, from July 2001 it is 570)	None 0 Child Support grant 1 Care dependency grant 2 Foster child grant 3 Child disability grant 4 Welfare funds from non government sources 5 Other_____ 6 (specify)	40a

31f. Where did you first hear of the grants	Social Worker 1 Health care worker 2 Community worker 3 Health clinic 4 Neighbour 5 Friend 6 Relative 7 Newspaper 8 Television 9 Other_____ 10	
32f. How long did it take between applying for the grant and actually receiving it		
33f. What problems, if any did you have in receiving the grant(s): 1. 2. 3.		
34f. Do you know about following grants. Circle all that apply. 1=Child support grant(R100) 2=Care dependency grant (R540) 3=Foster care grant (R410) 4= Disability grant(R 540)	 Yes 1 1 1 1	 No 2 2 2 2
35f. Do you (caregiver) work outside of the home to earn money? If yes, how many hours each week do you work _____	No, unemployed 0 Yes, circle all that apply Handicrafts 1 Harvesting/field work 2 Selling food 3 Shop keeper 4 Street vendor 5 Paid domestic work 6 Salaried work 7 Other_____8	
36f. **(IF THE CHILD IS LESS THAN 10 YEARS OLD)** Who takes care of the child when you are busy or away at work	Nobody 0 Grandmother 1 Grandfather 2 Older brother 3 Older sister 4 Older cousins 5 Maternal aunt 6 Paternal aunt 7 Others _____8	

37f. Who pays for the child's school fees and other related items	Nobody 0 Mother 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
38f. Who pays for the child's clothing	Nobody 0 Caregiver(You) 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
39f. Who pays for the child's food	Nobody 0 Caregiver(You) 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	

40f. Who pays for medical care of the child	Nobody 0 Caregiver(You) 1 Father 2 Other relatives 3 Household members 4 Family friends 5 Governmental funding 6 Money left behind by child's parents 7 Churches 8 Welfare funds 9 (Community/NGO's) 10 Other, specify_____11	
41f. What are the needs of the child that you are struggling to provide? (Circle all that apply)	None 0 School fees and other educational items 1 Food 2 Clothing 3 Transportation 4 Health care fees 5 Other 6 ,please specify	
42f. Please list the 3 most important things which will help your family in looking after the orphans? (DON"T READ LIST JUST USE CODE IF APPLICABLE) 1. 2. 3.	None 0 Food 1 Clothes 2 Shelter 3 Bed/Blankets 4 Help with school work 5 Transportation 6 Emotional support 7 Guidance 8 Medical problems 9 General supervision 10 Other_____ 11 (specify)	

DNK: Don't Know
Bold Faced and capped text is for the interviewer only and should not be read to the participants.

Appendix 4: Assumptions and Definitions

Assumptions:

3.1 Common problems of Orphans in South Africa (Hunter, 2000)

1. Large number of orphans per family
2. Increased household poverty
3. Lower nutritional status in fostering households with large number of children
4. Increased labor demands on children
5. Reduced access to education
6. Harsh treatment and abuse from step/foster parents
7. Segregation and isolation of orphans at meals
8. Loss of property and inheritance
9. Forced early marriage of female orphans
10. Higher mortality, more frequent illness
11. Abandonment
12. Lack of love, attention and affection
13. Grief for loss of parents, separated siblings
14. Defilement by guardians

3.2 Key determinants of orphan well being (Hunter, 2000)

1. Age and sex of the child
2. Death status of the parents (mother, father, brother)
3. Age of the guardian
4. Number of children and adults in the foster family
5. Proportion of orphaned children in a geographic area.
6. AIDS related stigma and discrimination
7. Access to health, education and social service)

Definitions

Caregiver: Caregiver defined as person living in the household who spends the most time caring for the child and often makes decision about what the child eats

Children: According to the UN, a human being between the ages of 0-10 is a child. The US Census Bureau uses the more traditional demographic category of a person under 15 years of age. Often "children" includes some combination of young people, youth and adolescents (Hunter, 2000)

Extended family: A group of people of many generations who consider themselves related for various purposes and who may not be resident together or even close by. It often includes grandparents, aunts, uncles, nieces, nephews, step relatives and in-laws (Hunter, 2000).

Family: Is a group of people related by blood or marriage that may or may not reside together (Hunter, 2000)

Household: A household is a person or group of persons that usually lives and eats together, sharing the same housing unit facilities and water (Hunter, 2000)

Norphans: Children who live in household containing maternal orphans but are not orphans themselves.

Orphans: Orphans are classified into three different types

Maternal orphans: Children under the age of 15 whose mothers have died

Paternal Orphans: Children under the age of 15 whose fathers have died

Double orphans: Children under the age of 15 whose mothers and fathers have both died (Hunter, 2000)

Weakened communities and societies: The communities where children live are weakened by premature adult deaths due to AIDS. As a consequence of these changes, social support for children and young people is diminishing in heavily affected communities. The remaining proportions of children who are not affected are living in societies with vastly poorer infrastructure and human resources. Access to health, education and social service is decreasing as wage earners fall sick and the disease draws off more skilled personnel and resources. In addition we have no way to factor in grief trauma and resulting social pathology (Hunter, 2000)

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ANNEX 6

TDCSP HIV/AIDS MED AMENDMENT WORKPLAN JAN-JULY 2002

This work plan has been compiled by intervention (MED, home based care, orphans) for ease of implementation. However, the issues of message development and sustainability are dealt with as cross cutting issues. The first column indicates which objectives will be met by the activities. The second column addresses recommendations from the MTE.

Objectives of the project:

OBJECTIVE 1: Households (HH) with acutely or chronically ill family members or families that have taken in orphans will maintain or improve their incomes through MED activities

OBJECTIVE 2: Increase in women and youth's ability to provide financially for their households and decrease their risk behaviour through their involvement in MED linked activities

OBJECTIVE 3: Increased awareness and response to HIV/AIDS epidemic among civil society, local institutions and intervention target groups

OBJECTIVE 4: Households with acutely/ chronically ill family members will have improved knowledge, skills and support to care for the chronically ill

OBJECTIVE 5 : Households and communities with orphans will have appropriate awareness and knowledge to care for orphans

OBJECTIVE 6: Project experiences and lessons for MED and care and support activities among vulnerable households will be documented and shared with policy makers , practitioners and communities in KZN, SA and beyond

OBJECTIVE 7: To ensure that effective program components can continue after project completion

MICROENTERPRISE DEVELOPMENT ACTIVITIES

Obj #	Evaluation recommendations	Activities	2002	2003													Outcome	Who responsible
			J	J	A	S	O	N	D	J	F	M	A	M	J	J		
1,2	Target vulnerable households for MED training	• Identify vulnerable households through community structures eg HBC givers, CHCs • Train members of vulnerable HH(with ill members, orphans) • Train women and youth	X	X X X													Targeted households receive MED training (160 + 40 people trained through Project an additional 300 trained through OADP and two MED (staff) trainers trained	MED Project Staff and DBSP

3	Link those not accepted for MED with skills training	Plan how to link those not accepted for MED with skills training	X														Skills training available to clients from vulnerable households who do not qualify for the MED training	DBSP staff + MED staff OADP craft trainers
O-bj #	**Evaluation recommendations**	**Activities**	**2002**							**2003**							**Outcome**	**Who responsible**
			J	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**		
1,2, 3	Linkages with outside markets (also link with LG)	Plan how to link MED trainees with markets through OADP and LG	X	X	X	X											New businesses linked to markets	OADP + MED staff
3, 4, 5	Community mobilisation for MED /HBC/ Orphanactivities	• MED community messages developed and disseminated • resource directory for opportunities	X X	X X													MED messages known by clients and community leadership and CB workers Resource directory with market opportunities	MED/HBC/ Orphan/ project staff and manager with DBSP MED staff/ OADP manager +market gateway
1,2	Orientation course for MED activities (numeracy and literacy)	• Design orientation course for MED training • Course used for screening potential trainees	X	X		X											Orientation Course Clients screened appropriately	DBSP MED staff
1,2	Transformational Leadership training for MED trainees (vision etc)	Train all MED trainees in TL		X	X	X	X	X									200 clients trained in basic TL	OADP Leadership Gateway
1,2	Design a section about microcredit as part of the MED training package	Design a section about microcredit as part of the MED training package	X														Micro-credit module incorporated into DPSU trainiing	WV + DBSP + NMCO
1,2	Strengthen coaching and monitoring for trainees	Strengthen coaching and monitoring for trainees: • Design monitoring timetable • Train MED staff in TL facilitation /coaching	X	X	X												Monitoring schedule in place and followed for each client 2 MED staff trained in TL facilitation and coaching	DBSP + MED staff TDCSP manager

Obj #	Evaluation recommendations	Activities	2002		2003												Outcome	Who responsible
			J	J	A	S	O	N	D	J	F	M	A	M	J	J		
1,2,7	Link with Microcredit institution: • MED continue through Bergville Business Advice Centre (BBAC) • MED capacity building	Plan sustainability of MED activities by • Planning takeover of MED training (OADP, DBSP + other sources of funding) • Build capacity of Bergville Business Advice Centre	X			X	X	X			X	X					BBAC administrator also trained as a MED trainer	Manager + DBSP
1	Finalize suitable tools for measuring baseline data for households participating in program interventions	• Evaluate HH expenditure questionnaire: Redesign if necessary • Complete HH expenditure questionnaire with new trainees • Do questionnaire with initial trainees to see shifts in income and expenditure	X X	 X X	 X 											x x	Tool finalized All trainees surveyed Comparison completed	HIVAN + manager Project staff + OADP staff End of project evaluation
2	Finalize suitable tools for measuring baseline data for households participating in program interventions	• Complete design of (sexual) Behavior surveillance questionnaire • Complete questionnaires with trainees • Do end of project survey for behaviour change	X	X	 X										x	 x X	Behavior surveillance tool finalized Each trainee surveyed Survey completed and analysed	Manager + HIVAN Project staff Outside evaluators

6,7	Develop strategies for broadly sharing lessons learned and strategies for the sustainability of the project components	Project experiences about MED shared Sustainability strategies developed and documented		X			X			X			X			X	Strategies documented and implemented	Manager and project staff

HOME BASED CARE ACTIVITIES

(In addition to the MTE of HBC, an internal evaluation of HBC was carried out - see appendix 14)

Obj #	Evaluations: recommendations	Activities planned	2002		2003												Outcome	Who responsible
			J	J	A	S	O	N	D	J	F	M	A	M	J	J		
4	Strengthen and consolidate referral system between HBCs, clinics and hospital	Finalize use of client carrier cards for clients discharged from hospital to HBCs	X	X	x	x	x	x	x	x	x	x	x	x	x	xn	carrier cards used for all hospital referrals	DOH – Hospital, clinics, HBcs and Project stafff
4	Refine and package HBC messages	Define core HBC messages Develop materials for transfer of messages	X	X													HBC messages defined, available to MED staff and CB workers	Staff and manager
7	Plan exit strategy/ sustainability for TDCSP MED HBC project	Plan sustainability/ other sources of funding / integration with other existing work and institutions (OADP)	X	X							X	X	X				Intervention and research will have alternative funding/ integrated into OADP	Staff and manager
1,2,4, 5	Link HBC with orphans and MED activities	• Share HBC project information &messages with all MED course participants • Share orphans project information and messages with all MED course participants • Recruit MED course participants from HH with ill family members, and orphans	X X X	X X	X X	X X X	X X	X X	X X	X X	X X	X X	X X	X X	X X	X X	HBC, orphans and MED activities are linked through messages	Project staff

4	Develop formal M&E system, formalise supervision structure for HBC and link to referral system and TDCSP district wide	• Plan + do regular monitoring, and evaluation of the work of HBC givers • write proposal to get funding for a HBC supervisor to set up systems and processes for 2 years	X X	X X				X				X			x	X x	M& E and supervision in place for HBC givers Municipal level + ward level supervisors for HBC defined and trained	Manager , DOH, OADP/ TDCSP manager, DOH HIVAN
Obj #	**Evaluations: recommendations**	**Activities planned**	**X2002**								**2003**						**Outcome**	**Who responsible**
			J	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**		
3,4	Message campaign against stigma, and sharing information about HBC	• Message development for HBC (see above) • Health days around positive living, caring for someone who is positive, basic HBC etc	X X	X X	X X	X X	X X	X X	X X	X X	X X	X X	X X	X X	X X	X X	Stigma reduced – increasing people coming for VCT to clinics and drop-in-centre	Manager /DOH and project staff HIVAN
3,4,5	Training : Provide training in counselling and first aid to HBC volunteers	• CL training for all HBC givers (COMPLETED) • TL training for all HBC givers • HIV/ AIDS counselling training for some HBC givers linked to VCT • Psychosocial care of OVC for some HBC givers • First Aid training to all HBC givers (complete) • Nutrition and HIV training: all HBC givers		 X X	 X	 X	 X X X	 X X X X									HBC givers trained with various skills	Manager to organize trainings With appropriate trainers
4	Monitor and Evaluate HBC	Evaluate what care patients in HBC receive, using tool developed for evaluation + LQAS Process	X	X				X				X				X	Monitoring results inform in-service training program for HBCs	Manager + HBC supervisors

4, 5	Develop wellbeing indicators	Develop indicators for wellbeing, use for evaluation of wellbeing of patients and families and orphans	X	X				X				X				X	Draft Indicators defined and tested	Manager + consultant
6	HBC experiences and lessons shared broadly among stakeholders	Share HBC lessons learned HBC conference for awareness raising and advocacy HBC program (COMPLETED)	X	X				X				X				X	Lessons and evaluations documented and record kept of stakeholders informed Conference held in Bergville and documented	Manager to facilitate HIVAN and Project staff

ORPHANS ACTIVITIES

Obj#	Evaluation: recommendations	Activities	2002		2003											Outcome	Who responsible
			J	J	A	S	O	N	D	J	F	M	A	M	J	J		
5, 3	Focus on children's rights, design targets for holistic community care for orphans	• Develop messages about childrens rights, and holistic community care for orphans • Disseminate messages to: MED trainees, Community Based (CB) workers and structures, Local Gov, different sectors etc • Evaluate coverage and effectiveness of messages	X X	X	X	X	X	X X	X	X	X	X X	X	X	X	X X	Messages and materials available for use in the community in Zulu All trainees are MED trainees, OADP staff, ward development committees trained in messages	Orphan staff and manager Project staff with OADP orphan core team
5	Research and advocate school feeding schemes and orphan managed food security garden and chicken projects within OADP	• Plan for food security for orphans as a survival right (School feeding schemes) • Evaluate whether orphans associated with the project have food security	X					X			X	X X	X			X	At a minimum, orphans within program are in the process of having food security needs met	Manager +Staff networking with OADP and local government

3,5	Facilitate education of OVC Encourage church involvement,	Mobilise churches and schools around orphan issues and their rights to food security, care and education + engage school teachers and principals in the project	X	X	X	X	X	X			X	X	X	X	X	X	At least two churches and two schools /ward mobilized	Project staff and OADP gateway Project
5	Facilitate orphan participation in the project as decision makers (age 15-25)	• Identify older orphans in various communities • Offer TL training so they can design their own future	X		X	X X	X	X									At least two orphan projects initiated in partnership with OADP Orphan project	Project staff and OADP Orphan and leadership projects

Obj #	**Evaluation: recommendations**	**Activities**	**2002**	**2003**													**Outcome**	**Who responsible**
			J	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**		
5	Have information of all orphans by ward and Compensate expectations raised by the orphan register	-Do 'damage control' through CB structures -Design a way of keeping records of orphans and their wellbeing without compromising their safety by having a register - HBC to refer new orphans to OADP on a monthly basis	X X X	X X	X X	X X	X X	X X			X X	X X	X X	X X	X X	X X	Local government and ward level committees understand purpose and benefits of orphan register	Project staff and manager
5,6	Orphan experiences and lessons shared broadly among stakeholders	Document and share experiences from the orphans project		X			X			X			X			X	Lessons and evaluations documented and record kept of stakeholders informed	Project staff and manager
7	Sustainability Plan for Orphan intervention	Develop a sustainability plan for the orphan project through OADP									X	X	X	X			Sustainability plan documented and implemented	Manager and staff